

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06465

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>A.A. Co.</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) <span style="float: right;">✓</span> a. STATE <u>MD.</u> b. COUNTY <u>Bolto - 03x-2</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>28</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore. 28 - Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne. Arundel Gen.</u>				d. STREET ADDRESS <u>115 Garden Ridge</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOSEPH DANIEL Middle Last First East</u>				<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>5</u> Year <u>1960</u>			
<b>5. SEX</b> <u>M.</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10/11/43</u>	<b>9. AGE</b> (In years last birthday) <u>16</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Ind</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Frederick Alfred</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Sylvia Levin</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Annapolis Hosp. Rec. Room.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>while swimming with friends - Sappington Yacht Yard</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>5 - 6 - 5 1960</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Sackett's Pond</u>		<b>20f. (City or town) (County) (State)</b> <u>  A.A.  MD.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>E. Linhardt</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>6/5/60</u>			
<b>EXAMINER'S NAME</b> (Type) <u>E. Linhardt</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Buried</u>	<b>22b. DATE THEREOF</b> <u>6/9/60</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Balto. Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Manhart + Son</u>		<b>ADDRESS</b> <u>28</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JUN 10 60</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>Robert L. Haines</u>		

TO DE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any dr. necessary, please see-  
 culate i certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be  
 forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,  
 or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

## CERTIFICATE OF DEATH

Reg. Dist. No. 06466

6503

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>25 Jefferson Place</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA M ARMIGER</u>				4. DATE OF DEATH Month Day Year <u>June 21 19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 7, 1870</u>	
9. AGE (In years lost birthday) yrs. <u>90</u>		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert County, Maryland</u>	
13. FATHER'S NAME <u>John Thomas King</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Phipps</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>J. Herbert Armiger- Son- same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>231X</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) <u>HYPERTENSION</u> (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>34 YRS</u> <u>10 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>16 MAY</u> , 19 <u>60</u> , to <u>21 JUNE</u> , 19 <u>60</u> that I last saw the deceased alive on <u>21 JUNE</u> , 19 <u>60</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Franklin Street, Annapolis, Md.</u> <u>June 21, 1960</u>							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.				PHYSICIAN'S NAME (Type) <u>Edward S. Beck MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 23, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>				22e. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05280

CERTIFICATE OF DEATH

05280

*[Faint, mostly illegible text on a form with multiple horizontal lines. Some legible fragments include:]*

NAME OF DECEASED  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
DATE OF DEATH  
PLACE OF DEATH  
SIGNATURE OF REGISTRAR  
OFFICE





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6532

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06467

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. LENGTH OF STAY IN 1b <u>35 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William FRANCIS Atwell</u>		4. DATE OF DEATH Month Day Year <u>June 24, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 23 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shodyside, Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard</u>		14. MOTHER'S MAIDEN NAME <u>Virginia L. Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-10-7693</u>	
17. INFORMANT <u>Mrs Sadie Atwell Edgewater Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Brochogenic carcinoma, left lung, far advanced</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 21, 1959</u> , to <u>June 24, 1960</u> , that I last saw the deceased alive on <u>June 24, 1960</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Barber C. Palmer, Jr.</u> M.D. <u>77 Franklin Street, Annapolis, Md.</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Barber C. Palmer, Jr., M.D.</u> <u>6/28/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/27/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		22d. LOCATION (City, town, or county) (State) <u>Galesville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Herduty</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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DATE OF DEATH

MD 2823

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6533

## CERTIFICATE OF DEATH

Reg. Dist. No.

06469

1. PLACE OF DEATH a. COUNTY <u>AA. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERN P.O. Route 1-Box 205</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GAMBRILLS STA. ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Also known as First John Middle B. Smith JOHN B. BLACKOWICZ</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 13-1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM.</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTA Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>MARKTON BLACKOWICZ</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-36-2613</u>	
17. INFORMANT <u>MRS. PELAGIA A. BLACKOWICZ</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRO-INTESTINAL HEMORRHAGE</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ADENO CARCINOMA, STOMACH</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 HRS.</u> <u>1 YR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>59</u> , to <u>JUNE</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-24</u> , 19 <u>60</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon C. Perry</u>		ADDRESS (Street, city or town, state) <u>Ellen Burns, Md</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>7-1-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-4-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Fields</u>	22d. LOCATION (City, town, or county) (State) <u>millersville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware - Home</u>		ADDRESS <u>Ellen Burns</u>	
24a. REC'D BY REGISTRAR <u>JUL 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06470  
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Annapolis Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ad. General Hospital</u>		d. STREET ADDRESS <u>16 Parole Street</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Brooks</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) yrs. <u>8</u> Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Clogget</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ruth Brooks, 16 Parole St. Annap.</u>	
17. INFORMANT <u>Ruth Brooks</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Under</u> DUE TO (c) <u>Under</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Under</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John [Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-20-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Best Gate Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese H. [Signature]</u>		ADDRESS <u>[Address]</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>	
DATE <u>JUN 21 '60</u>			

2063349XL6



6534

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>8 mo. 2 yrs 16 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3Y01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>2011 Walbrook Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>E.</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>6</b> Day <b>27</b> Year <b>1960</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1909 - April 27</b>		9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>27</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Brown</b>				14. MOTHER'S MAIDEN NAME <b>Blanche Bishop</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-05-1700</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicopyemia</b> <b>715X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Decubital Ulcers, Infected</b> DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Wernicke's Syndrome</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/22</b> , 19 <b>52</b> , to <b>6/27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/27</b> , 19 <b>60</b> , and that death occurred at <b>3:40 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Hildegard Heard Reissman</i>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md. 6/27/60</b>					
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>		<b>Crownsville State Hospital, Md. 6/27/60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/1/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Holstead</i>		ADDRESS <i>918 Druid Hill Ave</i>		24a. REC'D BY REGISTRAR <b>JUN 29 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

CERTIFICATE OF DEATH

1931

211 Madison Avenue

New York

Birthplace

Age 45

211 Madison Avenue

211 Madison Avenue

Death

Death

1931 - April 21

1931 - April 21

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

6535

CERTIFICATE OF DEATH

06472  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 111 Route 2 Point Pleasant</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Jane Brown</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/15/65</u>	
9. AGE (In years lost birthday) <u>94</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Woodstock, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rueben Cavey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Streback</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Maude Forney (daughter)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5</u>  <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/7/60</u> , 19 <u>60</u> , to <u>6/12/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/12/60</u> , 19 <u>60</u> , and that death occurred at <u>5.20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. <u>6/13/60</u> PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> <u>Glen Burnie, A.A. Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Granite, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter T. Davis, Jr., 4101 Edmonson Rd., Balto</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6532

XXXX 1913

XXXX 1913

XXXX 1913

XXXX 1913

OWN HOME

1913

1913

1913

1913



6536

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>A. A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 497 Rte #5</b>		d. STREET ADDRESS <b>Box 497 Rte #5</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MELVINA ELIZABETH BROWN</b>		4. DATE OF DEATH Month Day Year <b>JUNE 18 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/20/1889</b>
9. AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>A.A. Co. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm Edward Smith</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE Bolden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>ALBERT E. SMITH - PASADENA MD.</b>	
17. INFORMANT Address <b>ALBERT E. SMITH - PASADENA MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASC. DISEASE</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC NEPHROSCLEROSIS</b> DUE TO (c) <b>10 YRS.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UREMIA</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 20, 1960</b> , to <b>JUNE 18, 1960</b> , that I last saw the deceased alive on <b>JUNE 15, 1960</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur Lankford Jr.</b>		DATE SIGNED <b>June 19, 1960</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD JR.</b>		<b>Pasadena, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>6/22/60</b>	<b>Not Zion Church</b>	<b>Magdalen - Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marlene P. Ayer</b>		ADDRESS <b>638 N. GILMORE ST</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Lankford</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

NAME: **James Hamilton**  
RESIDENCE: **1100 1st Ave NE**  
DATE OF DEATH: **1/20/50**  
PLACE OF DEATH: **Home**  
CAUSE OF DEATH: **Myocardial Infarction**  
MANNER OF DEATH: **Natural**  
AGE: **45**  
SEX: **M**  
RACE: **W**  
BIRTH DATE: **1/10/05**  
BIRTH PLACE: **Wash DC**  
FATHER: **James Hamilton**  
MOTHER: **Elizabeth Hamilton**  
MARITAL STATUS: **Married**  
OCCUPATION: **Engineer**  
EDUCATION: **High School**  
RELIGION: **Methodist**  
PREVIOUS ILLNESS: **None**  
TREATMENT: **None**  
BURIAL PLACE: **Wash DC**  
CEREMONY: **Yes**  
OFFICIAL: **Dr. J. H. Smith**  
DATE: **1/20/50**

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06474

6532

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>NEW YORK</b> b. COUNTY <b>Monroe</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT GEORGE G MEADE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROCKPORT</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. ARMY HOSPITAL, FORT MEADE Maryland</b>				d. STREET ADDRESS <b>167 MAIN ST</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>C. T.</b> Last <b>BUSH</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-23-39</b>		9. AGE (In years last birthday) <b>21</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STUDENT</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles T. Bush</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Button</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Brockport N.Y.</b> <b>Father(Charles T. Bush 167 Main St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN INJURY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>AUTO ACCIDENT BALT-WASH PKWAY AT #175</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>3 JUNE 1960</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>PARKWAY</b>		20f. (City or town) (County) (State) <b>PARKWAY &amp; HWAY #175</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H Faubert</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>GUSTAVE H FAUBERT</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION June-6-1960</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>London Park Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard J. Lighter</i>				24. REC'D BY REGISTRAR DATE <b>JUN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <i>...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WYOMING STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6538

## CERTIFICATE OF DEATH

06475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover, R.M.A.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hanover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>1 R.F.A. - Dorsey Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>S.</u> Last <u>Butler</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/20/1890</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad-haberer Railroadng</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dorsey, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dennis Butler</u>				14. MOTHER'S MAIDEN NAME <u>Eveline Culver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Irene B. Hebron - Box 300 Hanover, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Quadreplegia</u> DUE TO (c) <u>Auto mobile accident.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>21 months</u> <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>car ran in back of truck. He was thrown out</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>11</u> p. m. <u>1959</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Washington Express Co.</u>				20f. (City or town) <u>St. Marys</u> (County) <u>A.A.</u> (State) <u>Md.</u>			
21. I certify that I attended the deceased from <u>June 23, 1960</u> to <u>June 25, 1960</u> , that I last saw the deceased alive on <u>June 23, 1960</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.				ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>6/25/60.</u>			
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Hanover A.A. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>209150/Alton</u> ADDRESS <u>1348 N. Calhoun</u>				24a. REC'D BY REGISTRAR DATE <u>27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1938

DEPARTMENT OF HEALTH BALTIMORE		DATE OF DEATH 1938	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		NAME OF PHYSICIAN [Illegible]	
NAME OF FUNERAL HOME [Illegible]		NAME OF BURIAL PLACE [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF WITNESS [Illegible]	
NAME OF REGISTRAR [Illegible]		NAME OF CLERK [Illegible]	



6539

Item 1 Film G265 6-20-60 et

## CERTIFICATE OF DEATH

06476

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Campbell</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lynchburg Va. 83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				d. STREET ADDRESS <u>720 Euclid Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eligah</u> First <u>Witt</u> Middle <u>Callahan</u> Last				4. DATE OF DEATH <u>June 13</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3-1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Campbell Co. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>James O. Callahan</u>				14. MOTHER'S MAIDEN NAME <u>Martha Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Margaret Callahan</u> Address <u>720 Euclid Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>SCLEROTIC CARDIOVASCULAR D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/13</u> , 19 <u>60</u> , to <u>6/13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/13</u> , 19 <u>60</u> , and that death occurred at <u>3:30 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Felix Gruenberg</u> M.D.				ADDRESS (Street, city or town, state) <u>P.O. Box 97 Ocean View</u>			
PHYSICIAN'S NAME (Type) <u>Felix Gruenberg</u>				DATE SIGNED <u>6/13/1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>16 June 1960</u>		<u>Spring Hill Cemetery</u>		<u>Lynchburg, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Grant</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6506  
CERTIFICATE OF DEATH

Reg. Dist. No. 06477

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112 Archwood Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>J</u> Last <u>Cole</u>				4. DATE OF DEATH Month <u>6</u> - Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-1878</u>	9. AGE (In years last birthday) yrs. <u>81</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Michael F. Quinn</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Lannon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mary M. Cole</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Coronary - Vascular</u> DUE TO (c) <u>Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Funeralists</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1954</u> to <u>Jan 20, 1960</u> that I last saw the deceased alive on <u>Jan 20, 1960</u> and that death occurred at <u>2:54</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert L. Anderson</u>				ADDRESS (Street, city or town, state) <u>Annapolis, Md</u>		DATE SIGNED <u>6/21/60</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT L. ANDERSON</u>				<u>ANNAPOLIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 22-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sues</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12 & 14 Film G266 7/5/60 iwk

## CERTIFICATE OF DEATH

06478  
Reg. Dist. No.

6540

1. PLACE OF DEATH o. COUNTY <b>AA</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>50 BROOKLYN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>406 TOWNSEND AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>H.</b> Last <b>CORBMAN</b>		4. DATE OF DEATH Month <b>6</b> Day <b>25</b> Year <b>19 60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/31/01</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Agent Steam fitter union 438</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canada</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>Miniette unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>177 X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yr</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 11</b> , 19 <b>58</b> , to <b>June 25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/25</b> , 19 <b>60</b> , and that death occurred at <b>1:37</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel Miller</b> M.D.		ADDRESS (Street, city or town, state) <b>4321 Starport Rd</b>	
PHYSICIAN'S NAME (Type) <b>Dr Daniel - Miller</b>		DATE SIGNED <b>Balt 14 Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>	22b. DATE THEREOF <b>6/28/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore 25, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>MCCULLY FUNERAL HOMES 130 E.FORT AVE. # 30</b>		24a. REC'D BY REGISTRAR <b>JUN 28 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

1



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06429

6541

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena P.O.</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Pasadena P.O.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. #9 Box 413</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>AUDREY COURTNEY</b>				4. DATE OF DEATH Month Day Year <b>June 18, 19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 26, 1893</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>G. William Schafer</b>				14. MOTHER'S MAIDEN NAME <b>Emma Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. Irwin G. Courtney-Pasadena, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>hypertensive cardiovascular disease</b> DUE TO (b) <b>disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/16/60</b> 19 to <b>6/18/60</b> 19, that (I) (we) last saw the deceased alive on <b>6/16/60</b> 19, and that death occurred at <b>4 A.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Irwin G. Courtney</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/18/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Irwin G. Courtney</b>				22d. ADDRESS <b>5-Finley Ave. N.E. Glen Burnie, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/21/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tucker</b> ADDRESS <b>Baltimore, Md.</b>				25a. REC'D BY REGISTRAR <b>JUN 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 26

CA 100, 3011

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06489

Reg. Dist. No.

6542

1. PLACE OF DEATH a. COUNTY <i>AA -</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Severn</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severn</i>				c. LENGTH OF STAY IN 1b <i>24 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 267 - R2</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Harry Keyner Crawford</i>				4. DATE OF DEATH Month Day Year <i>6 30 1960</i>			
5. SEX <i>m</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 11 - 1906</i>	
9. AGE (In years last birthday) <i>54 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Mechanic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Trucks</i>			
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>John Crawford</i>				14. MOTHER'S MAIDEN NAME <i>Annie Beis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>114-405830</i>			
17. INFORMANT <i>Lottie Crawford - Severn</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Rungs -</i> DUE TO <i>163X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Metastatic Ca of intestine -</i> DUE TO <i>6 mo -</i> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1940</i> , to <i>6/30</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>6/30</i> , 19 <i>60</i> , and that death occurred at <i>11 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chas. L. Ball, Jr.</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>6/30/60</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-4-1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>New Haven Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Blow By Blow Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert P. Ware - General Home &amp; Address</i>				24a. REC'D BY REGISTRAR <i>Jul 5 '60</i>			
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frawe</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BROWN  
TWO TWENTY TWO

NAME OF DECEASED		WILLIAM BROWN	
AGE		TWO TWENTY TWO	
SEX		MALE	
RACE		WHITE	
DATE OF DEATH		JANUARY 1919	
PLACE OF DEATH		BALTIMORE, MARYLAND	
CAUSE OF DEATH		TUBERCULOSIS OF LUNGS	
DISEASE OR INJURY		TUBERCULOSIS OF LUNGS	
PERIOD OF ILLNESS		SIX MONTHS	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
DATE OF BIRTH		JANUARY 1919	
OCCUPATION		LABORER	
EDUCATION		HIGH SCHOOL	
MARRIAGE		MARRIED	
SPOUSE		JANE BROWN	
CHILDREN		ONE	
SIGNATURE OF DECEASED		WILLIAM BROWN	
SIGNATURE OF WITNESS		JANE BROWN	
SIGNATURE OF PHYSICIAN		J. B. BROWN	
SIGNATURE OF CLERK		J. B. BROWN	
SIGNATURE OF JUDGE		J. B. BROWN	
SIGNATURE OF SHERIFF		J. B. BROWN	
SIGNATURE OF CORONER		J. B. BROWN	
SIGNATURE OF JURY		J. B. BROWN	
SIGNATURE OF COURT		J. B. BROWN	
SIGNATURE OF STATE		J. B. BROWN	
SIGNATURE OF NATION		J. B. BROWN	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6543

## CERTIFICATE OF DEATH

Reg. Dist. No.

06481

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn RFD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Severn RFD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Somerset Ave. Delmont</u>		d. STREET ADDRESS <u>1 Somerset Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas L. Ditty, Sr.</u>		4. DATE OF DEATH <u>June 16, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1888</u> <u>28th Aug. 1898</u> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cemetery Worker (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glen Haven Cemetery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Ditty</u>		14. MOTHER'S MAIDEN NAME <u>Daucus A. Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-0890</u>	
17. INFORMANT <u>Mr. Charles Ditty</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Caecum</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>60</u> , to <u>June</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>60</u> , and that death occurred at <u>94</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles R. MacDonald</u> M.D.		ADDRESS (Street, city or town, state) <u>204 Chapin Hwy. Glen Burnie, Md.</u> DATE SIGNED <u>6-17-60</u>	
PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald</u>		<u>Glen Burnie, Md.</u> <u>12th June 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>20th June 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hines</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR		SIGNATURE OF COUNTY CLERK		SIGNATURE OF STATE CLERK		SIGNATURE OF FEDERAL CLERK	

DIVISION OF VITAL RECORDS  
 BALTIMORE, MARYLAND

1

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE PHYSICIAN, CLERK, WITNESS, DECEASED, NEXT OF KIN, BURIAL OFFICIAL, REGISTRAR, COUNTY CLERK, STATE CLERK, AND FEDERAL CLERK.



## 6507

## CERTIFICATE OF DEATH

06482

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL - Millersville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Jumpers Hole Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Beverly</b>		First <b>Beverly</b>		Middle <b>DIXON</b>		Last <b>DIXON</b>	
4. DATE OF DEATH <b>June</b>		Month <b>June</b>		Day <b>2</b>		Year <b>1960</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 Aug 1886</b>	
9. AGE (In years last birthday) <b>73</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter (ret.)</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-01-0999B</b>		17. INFORMANT <b>Mr. James Dixon</b>		Address <b>136 Dutton Ave Annapolis Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X Cardiovascular thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1960</b> , 19 <b>Jan. 2, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 25, 1960</b> , and that death occurred at <b>6:40A.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>John L. Hedeman</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <b>22d. ADDRESS</b> <b>121 Cathedral St., Annapolis, Md.</b>		22b. DATE SIGNED <b>6/2/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6 June 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Howard Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. V. Ling</b>				ADDRESS <b>Shaw Bureau, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 8 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Carlton S. Thomas</b>			

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## 06483

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>5 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL - Severn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George</b>		First <b>Albert</b>		Last <b>DOWNS</b>		4. DATE OF DEATH Month <b>June</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-24-1885</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. UNDER 1 YEAR Months <b>12</b>		10. UNDER 24 HRS. Days <b>12</b>		10. UNDER 24 HRS. Hours <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Dorros</b>		14. MOTHER'S MAIDEN NAME <b>Alas Jenkins</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>123-45-6789</b>	
17. INFORMANT <b>Anthony Dorros</b>		18. ADDRESS <b>W. River Md</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute myocardial infarction</b> DUE TO (c) <b>10 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/12</b> 19 <b>60</b> , to <b>6/12</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>6/12</b> 19 <b>60</b> , and that death occurred at <b>9:10 P.</b> M., from the causes and on the date stated above.		22a. SIGNATURE <b>John L. Hedeman</b>		22b. DATE SIGNED <b>6/12/60</b>		22c. PHYSICIAN'S NAME (Type) <b>John L. Hedeman</b>	
22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried 6-17-1960</b>		23b. DATE THEREOF <b>6-17-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chesapeake Memorial</b>	
23d. LOCATION (City, town, or county) (State) <b>Chesapeake Md</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reesett</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 17 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove corban paper. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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6544

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06484

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville (Elvaton)</i> c. LENGTH OF STAY IN 1b <i>4 yrs -</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Elvaton Road (Rt. 1) - Box 182</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville (Elvaton)</i> d. STREET ADDRESS <i>Elvaton Rd. Rt. 1 - Box 182</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Sophia</i> Middle <i>S-</i> Last <i>Emge</i>		4. DATE OF DEATH Month <i>June</i> Day <i>11</i> Year <i>1960</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>23 Aug 1970</i>	9. AGE (In years last birthday) <i>89</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto., MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.B.</i>
13. FATHER'S NAME <i>George Stemler</i>		14. MOTHER'S MAIDEN NAME <i>Mary (Unknown)</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Phyllis A. Richardson</i> Address <i>Same As #2</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO <i>Pulmonary Edema</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>15 yrs</i> (c) <i>Senility</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 min</i> <i>2 wks</i> <i>15 yrs</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> 19 p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11/2</i> 19 <i>52</i> to <i>6/10</i> 19 <i>60</i> that (I) (we) last saw the deceased alive on <i>6/10</i> 19 <i>60</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.						
22a. SIGNATURE <i>R. W. Richardson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>R. W. RICHARDSON</i>		22d. ADDRESS <i>715 - Cotter Rd Glen Burnie MD.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>14 June 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>London Park</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. MD.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. V. Singleton</i>		ADDRESS <i>Glen Burnie, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 15 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 11th inst. in relation to the above mentioned matter.  
I am sorry to hear that you are having trouble with the machine.  
I will try to get it fixed for you as soon as possible.  
Very truly yours,  
J. M. [Signature]  
[Address]



## CERTIFICATE OF DEATH

Reg. Dist. No.

06485

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Selby-on-the-Bay</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Selby-on-the-Bay</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fifth Avenue</b>		d. STREET ADDRESS <b>Fifth Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRANKLIN</b> First <b>VERNA</b> Middle <b>FRANKLIN</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1910</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spinner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cotton Textile</b>	11. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Joseph Knott</b>		14. MOTHER'S MAIDEN NAME <b>Martha Arrington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>James H. Franklin</b> Address <b>2</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>173.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic carcinomatosis of bladder &amp; kidney</b> (c) <b>Primary carcinoma of right ovary</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 months</b> <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 5, 1960</b> , to <b>June 30, 1960</b> , that I last saw the deceased alive on <b>June 30, 1960</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sylvia M. Lim</b>		DATE SIGNED <b>July 2, 1960</b>	
PHYSICIAN'S NAME (Type) <b>Sylvia M. Lim</b>		ADDRESS (Street, city or town, state) <b>Rt. 1 Box 277-M Edgewater, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-3-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor and Sons</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 5 '60</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6562

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SERVICE		12. GRADE		13. PAY		14. DUTY		15. STATUS		16. GRADE		17. PAY		18. DUTY		19. STATUS		20. GRADE		21. PAY		22. DUTY		23. STATUS		24. GRADE		25. PAY		26. DUTY		27. STATUS		28. GRADE		29. PAY		30. DUTY		31. STATUS		32. GRADE		33. PAY		34. DUTY		35. STATUS		36. GRADE		37. PAY		38. DUTY		39. STATUS		40. GRADE		41. PAY		42. DUTY		43. STATUS		44. GRADE		45. PAY		46. DUTY		47. STATUS		48. GRADE		49. PAY		50. DUTY		51. STATUS		52. GRADE		53. PAY		54. DUTY		55. STATUS		56. GRADE		57. PAY		58. DUTY		59. STATUS		60. GRADE		61. PAY		62. DUTY		63. STATUS		64. GRADE		65. PAY		66. DUTY		67. STATUS		68. GRADE		69. PAY		70. DUTY		71. STATUS		72. GRADE		73. PAY		74. DUTY		75. STATUS		76. GRADE		77. PAY		78. DUTY		79. STATUS		80. GRADE		81. PAY		82. DUTY		83. STATUS		84. GRADE		85. PAY		86. DUTY		87. STATUS		88. GRADE		89. PAY		90. DUTY		91. STATUS		92. GRADE		93. PAY		94. DUTY		95. STATUS		96. GRADE		97. PAY		98. DUTY		99. STATUS		100. GRADE		101. PAY		102. DUTY		103. STATUS		104. GRADE		105. PAY		106. DUTY		107. STATUS		108. GRADE		109. PAY		110. DUTY		111. STATUS		112. GRADE		113. PAY		114. DUTY		115. STATUS		116. GRADE		117. PAY		118. DUTY		119. STATUS		120. GRADE		121. PAY		122. DUTY		123. STATUS		124. GRADE		125. PAY		126. DUTY		127. STATUS		128. GRADE		129. PAY		130. DUTY		131. STATUS		132. GRADE		133. PAY		134. DUTY		135. STATUS		136. GRADE		137. PAY		138. DUTY		139. STATUS		140. GRADE		141. PAY		142. DUTY		143. STATUS		144. GRADE		145. PAY		146. DUTY		147. STATUS		148. GRADE		149. PAY		150. DUTY		151. STATUS		152. GRADE		153. PAY		154. DUTY		155. STATUS		156. GRADE		157. PAY		158. DUTY		159. STATUS		160. GRADE		161. PAY		162. DUTY		163. STATUS		164. GRADE		165. PAY		166. DUTY		167. STATUS		168. GRADE		169. PAY		170. DUTY		171. STATUS		172. GRADE		173. PAY		174. DUTY		175. STATUS		176. GRADE		177. PAY		178. 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GRADE		265. PAY		266. DUTY		267. STATUS		268. GRADE		269. PAY		270. DUTY		271. STATUS		272. GRADE		273. PAY		274. DUTY		275. STATUS		276. GRADE		277. PAY		278. DUTY		279. STATUS		280. GRADE		281. PAY		282. DUTY		283. STATUS		284. GRADE		285. PAY		286. DUTY		287. STATUS		288. GRADE		289. PAY		290. DUTY		291. STATUS		292. GRADE		293. PAY		294. DUTY		295. STATUS		296. GRADE		297. PAY		298. DUTY		299. STATUS		300. GRADE		301. PAY		302. DUTY		303. STATUS		304. GRADE		305. PAY		306. DUTY		307. STATUS		308. GRADE		309. PAY		310. DUTY		311. STATUS		312. GRADE		313. PAY		314. DUTY		315. STATUS		316. GRADE		317. PAY		318. DUTY		319. STATUS		320. GRADE		321. PAY		322. DUTY		323. STATUS		324. GRADE		325. PAY		326. DUTY		327. STATUS		328. GRADE		329. PAY		330. DUTY		331. STATUS		332. GRADE		333. PAY		334. DUTY		335. STATUS		336. GRADE		337. PAY		338. DUTY		339. STATUS		340. GRADE		341. PAY		342. DUTY		343. STATUS		344. GRADE		345. PAY		346. DUTY		347. STATUS		348. GRADE		349. PAY		350. DUTY		351. STATUS		352. GRADE		353. PAY		354. DUTY		355. STATUS		356. GRADE		357. PAY		358. DUTY		359. STATUS		360. GRADE		361. PAY		362. DUTY		363. STATUS		364. GRADE		365. PAY		366. DUTY		367. STATUS		368. GRADE		369. PAY		370. DUTY		371. STATUS		372. GRADE		373. PAY		374. DUTY		375. STATUS		376. GRADE		377. PAY		378. DUTY		379. STATUS		380. GRADE		381. PAY		382. DUTY		383. STATUS		384. GRADE		385. PAY		386. DUTY		387. STATUS		388. GRADE		389. PAY		390. DUTY		391. STATUS		392. GRADE		393. PAY		394. DUTY		395. STATUS		396. GRADE		397. PAY		398. DUTY		399. STATUS		400. GRADE		401. PAY		402. DUTY		403. STATUS		404. GRADE		405. PAY		406. DUTY		407. STATUS		408. GRADE		409. PAY		410. DUTY		411. STATUS		412. GRADE		413. PAY		414. DUTY		415. STATUS		416. GRADE		417. PAY		418. DUTY		419. STATUS		420. GRADE		421. PAY		422. DUTY		423. STATUS		424. GRADE		425. PAY		426. DUTY		427. STATUS		428. GRADE		429. PAY		430. DUTY		431. STATUS		432. GRADE		433. PAY		434. DUTY		435. STATUS		436. GRADE		437. PAY		438. DUTY		439. STATUS		440. GRADE		441. PAY		442. DUTY		443. STATUS		444. GRADE		445. PAY		446. DUTY		447. STATUS		448. GRADE		449. PAY		450. DUTY		451. STATUS		452. GRADE		453. PAY		454. DUTY		455. STATUS		456. GRADE		457. PAY		458. DUTY		459. STATUS		460. GRADE		461. PAY		462. DUTY		463. STATUS		464. GRADE		465. PAY		466. DUTY		467. STATUS		468. GRADE		469. PAY		470. DUTY		471. STATUS		472. GRADE		473. PAY		474. DUTY		475. STATUS		476. GRADE		477. PAY		478. DUTY		479. STATUS		480. GRADE		481. PAY		482. DUTY		483. STATUS		484. GRADE		485. PAY		486. DUTY		487. STATUS		488. GRADE		489. PAY		490. DUTY		491. STATUS		492. GRADE		493. PAY		494. DUTY		495. STATUS		496. GRADE		497. PAY		498. DUTY		499. STATUS		500. GRADE		501. PAY		502. DUTY		503. STATUS		504. GRADE		505. PAY		506. DUTY		507. STATUS		508. GRADE		509. PAY		510. DUTY		511. STATUS		512. GRADE		513. PAY		514. DUTY		515. STATUS		516. GRADE		517. PAY		518. DUTY		519. STATUS		520. GRADE		521. PAY		522. DUTY		523. STATUS		524. GRADE		525. PAY		526. DUTY		527. STATUS		528. GRADE		529. PAY		530. DUTY		531. STATUS		532. GRADE		533. PAY		534. DUTY		535. STATUS		536. GRADE		537. PAY		538. DUTY		539. STATUS		540. GRADE		541. PAY		542. DUTY		543. STATUS		544. GRADE		545. PAY		546. DUTY		547. STATUS		548. GRADE		549. PAY		550. DUTY		551. STATUS		552. GRADE		553. PAY		554. DUTY		555. STATUS		556. GRADE		557. PAY		558. DUTY		559. STATUS		560. GRADE		561. PAY		562. DUTY		563. STATUS		564. GRADE		565. PAY		566. DUTY		567. STATUS		568. GRADE		569. PAY		570. DUTY		571. STATUS		572. GRADE		573. PAY		574. DUTY		575. STATUS		576. GRADE		577. PAY		578. DUTY		579. STATUS		580. GRADE		581. PAY		582. DUTY		583. STATUS		584. GRADE		585. PAY		586. DUTY		587. STATUS		588. GRADE		589. PAY		590. DUTY		591. STATUS		592. GRADE		593. PAY		594. DUTY		595. STATUS		596. GRADE		597. PAY		598. DUTY		599. STATUS		600. GRADE		601. PAY		602. DUTY		603. STATUS		604. GRADE		605. PAY		606. DUTY		607. STATUS		608. GRADE		609. PAY		610. DUTY		611. STATUS		612. GRADE		613. PAY		614. DUTY		615. STATUS		616. GRADE		617. PAY		618. DUTY		619. STATUS		620. GRADE		621. PAY		622. DUTY		623. STATUS		624. GRADE		625. PAY		626. DUTY		627. STATUS		628. GRADE		629. PAY		630. DUTY		631. STATUS		632. GRADE		633. PAY		634. DUTY		635. STATUS		636. GRADE		637. PAY		638. DUTY		639. STATUS		640. GRADE		641. PAY		642. DUTY		643. STATUS		644. GRADE		645. PAY		646. DUTY		647. STATUS		648. GRADE		649. PAY		650. DUTY		651. STATUS		652. GRADE		653. PAY		654. DUTY		655. STATUS		656. GRADE		657. PAY		658. DUTY		659. STATUS		660. GRADE		661. PAY		662. DUTY		663. STATUS		664. GRADE		665. PAY		666. DUTY		667. STATUS		668. GRADE		669. PAY		670. DUTY		671. STATUS		672. GRADE		673. PAY		674. DUTY		675. STATUS		676. GRADE		677. PAY		678. DUTY		679. STATUS		680. GRADE		681. PAY		682. DUTY		683. STATUS		684. GRADE		685. PAY		686. DUTY		687. STATUS		688. GRADE		689. PAY		690. DUTY		691. STATUS		692. GRADE		693. PAY		694. DUTY		695. STATUS		696. GRADE		697. PAY		698. DUTY		699. STATUS		700. GRADE		701. PAY		702. DUTY		703. STATUS		704. GRADE		705. PAY		706. DUTY		707. STATUS		708. GRADE		709. PAY		710. DUTY		711. STATUS		712. GRADE		713. PAY		714. DUTY		715. STATUS		716. GRADE		717. PAY		718. DUTY		719. STATUS		720. GRADE		721. PAY		722. DUTY		723. STATUS		724. GRADE		725. PAY		726. DUTY		727. STATUS		728. GRADE		729. PAY		730. DUTY		731. STATUS		732. GRADE		733. PAY		734. DUTY		735. STATUS		736. GRADE		737. PAY		738. DUTY		739. STATUS		740. GRADE		741. PAY		742. DUTY		743. STATUS		744. GRADE		745. PAY		746. DUTY		747. STATUS		748. GRADE		749. PAY		750. DUTY		751. STATUS		752. GRADE		753. PAY		754. DUTY		755. STATUS		756. GRADE		757. PAY		758. DUTY		759. STATUS		760. GRADE		761. PAY		762. DUTY		763. STATUS		764. GRADE		765. PAY		766. DUTY		767. STATUS		768. GRADE		769. PAY		770. DUTY		771. STATUS		772. GRADE		773. PAY		774. DUTY		775. STATUS		776. GRADE		777. PAY		778. DUTY		779. STATUS		780. GRADE		781. PAY		782. DUTY		783. STATUS		784. GRADE		785. PAY		786. DUTY		787. STATUS		788. GRADE		789. PAY		790. DUTY		791. STATUS		792. GRADE		793. PAY		794. DUTY		795. STATUS		796. GRADE		797. PAY		798. DUTY		799. STATUS		800. GRADE		801. PAY		802. DUTY		803. STATUS		804. GRADE		805. PAY		806. DUTY		807. STATUS		808. GRADE		809. PAY		810. DUTY		811. STATUS		812. GRADE		813. PAY		814. DUTY		815. STATUS		816. GRADE		817. PAY		818. DUTY		819. STATUS		820. GRADE		821. PAY		822. DUTY		823. STATUS		824. GRADE		825. PAY		826. DUTY		827. STATUS		828. GRADE		829. PAY		830. DUTY		831. STATUS		832. GRADE		833. PAY		834. DUTY		835. STATUS	
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

65486

## CERTIFICATE OF DEATH

Reg. Dist. No. 06486

1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>ma</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sombrills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Sombrills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PO Box 504 Defence Highway</u>				d. STREET ADDRESS <u>PO Box 504 Defence Highway</u>			
3. NAME OF DECEASED (Type or print) <u>Otto</u> First Middle Last				4. DATE OF DEATH Month <u>6</u> - Day <u>10</u> - Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 13 1898</u>	
9. AGE (In years lost, birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Albert Fricke</u>				14. MOTHER'S MAIDEN NAME <u>Emma Reimer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-30-3411</u>		17. INFORMANT <u>Martha Fricke</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Polycystic carcinoma of liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastases</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 wks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-29</u> , 19 <u>60</u> , to <u>6-10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-10</u> , 19 <u>60</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>45 Franklin St. Annapolis Md</u> DATE SIGNED <u>6-13-60</u>							
ACTUAL SIGNATURE <u>Edith Rodler</u>				M.D. <u>45 Franklin St. Annapolis Md</u>			
PHYSICIAN'S NAME (Type) <u>EDITH RODLER</u>				<u>45 FRANKLIN ST. ANNAPOLIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-13-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Son</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12 & 14 Film G266 7/5/60 iwk

# CERTIFICATE OF DEATH

Reg. Dist. No. 06487

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>M.D.</b> b. COUNTY <b>ANN.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>50 ARUNDEL Co - ANN.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>14710 RITCHIE HWY</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS G. George</b>		4. DATE OF DEATH <b>6-16-1960</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Greece</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George</b>		14. MOTHER'S MAIDEN NAME <b>Gregoria Preneas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 16, 1960</b> , to <b>June 16, 1960</b> , that I last saw the deceased alive on <b>June 16, 1960</b> , and that death occurred at <b>11 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Eugene Schnitzer</b>		DATE SIGNED <b>6-18-60</b>	
PHYSICIAN'S NAME (Type) <b>Eugene Schnitzer, M.D.</b>		ADDRESS (Street, city or town, state) <b>3904 S. HANOVER ST Baltimore 25, Md.</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>6-20-60</b>	<b>Greek, Evangelismas</b>	<b>Balto - md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lambros Inc. 440 E. North</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 22 1960</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

6548

06488

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>25 yrs. 29 days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>								d. STREET ADDRESS <b>506 Elder, N.W.</b>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mark</b> Middle <b>Grant</b> Last <b>Grant</b>				4. DATE OF DEATH Month <b>6</b> Day <b>14</b> Year <b>1960</b>															
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1881</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>79</b>		IF UNDER 24 HRS. Days <b>14</b> Hours <b>1960</b> Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles H. Grant</b>				14. MOTHER'S MAIDEN NAME <b>Mary Dixon</b>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Hospital Records</b>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Hypostatic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Ca of Prostate Gland</b> DUE TO (c) -----												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----															
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. -----				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>factory, street, office bldg., etc.</b>				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>5/15</b> to <b>6/14</b> , 19 <b>60</b> , that (I) (we) lost saw the deceased alive on <b>6/14</b> , 19 <b>60</b> , and that death occurred at <b>1:00</b> A.M. from the causes and on the date stated above.																			
22a. SIGNATURE <i>L. Benedict</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>6/14/60</b>											
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>				22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				23b. DATE THEREOF <b>6/15/1960</b>				23c. NAME OF CEMETERY OR CREMATORY <b>University of Md</b>				23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>				ADDRESS <b>1080 Washington St</b>				25a. REC'D BY REGISTRAR <b>DATE JUN 20 '60</b>				25b. REGISTRAR'S SIGNATURE <i>Carlton S. Howard</i>							

CERTIFICATE OF DEATH

NAME

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

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*[Handwritten signature]*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06489

Reg. Dist. No.

5549

1. PLACE OF DEATH o. COUNTY <u>A. A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> c. LENGTH OF STAY IN lb <u>3 mos 12 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A. A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kaellwood MANOR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Grayling Jr.</u> Last <u></u>		4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/26/1888</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>motion picture oper. slow moving</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto City, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Grayling Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Vogle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-03-9722</u>	
17. INFORMANT <u>John Grayling III</u>		Address <u>Severn Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Death Cerebral Failure with complications</u> DUE TO <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Complications left leg back</u> (c) <u>Complications left leg back</u>		INTERVAL BETWEEN ONSET AND DEATH <u>260X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardio Vase Renal Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 10, 1960</u> to <u>June 29, 1960</u> that I last saw the deceased alive on <u>June 28/60</u> and that death occurred at <u>9:45 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph L. Lipskey</u> M.D.		ADDRESS (Street, city or town, state) <u>Calverton Md</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKEY</u>		DATE SIGNED <u>7-1-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-2-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenn Burnie Ceme</u>		22d. LOCATION (City, town, or county) (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Burns</u> ADDRESS <u>Glenn Burnie</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
DATE <u>JUL 5 '60</u>		24b. REGISTRAR'S SIGNATURE	

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CERTIFICATE OF DEATH

Date of Death _____		Place of Death _____	
Name of Deceased _____		Sex _____	
Age _____		Race _____	
Date of Birth _____		Place of Birth _____	
Cause of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	

IN CASE OF DEATH  
 OF A PERSON  
 WHOSE NAME  
 IS ON THE  
 LIST OF  
 DECEASED  
 PERSONS  
 IN THE  
 CITY OF  
 BALTIMORE  
 THE  
 DEATH  
 SHALL BE  
 RECORDED  
 IN THE  
 OFFICE  
 OF THE  
 HEALTH  
 DEPARTMENT  
 OF THE  
 CITY OF  
 BALTIMORE  
 AND  
 A  
 CERTIFICATE  
 OF DEATH  
 SHALL BE  
 ISSUED  
 TO THE  
 NEXT OF KIN  
 OR TO THE  
 PERSON  
 WHOSE  
 NAME IS  
 ON THE  
 LIST OF  
 DECEASED  
 PERSONS  
 IN THE  
 CITY OF  
 BALTIMORE  
 AND  
 A  
 CERTIFICATE  
 OF DEATH  
 SHALL BE  
 ISSUED  
 TO THE  
 NEXT OF KIN  
 OR TO THE  
 PERSON  
 WHOSE  
 NAME IS  
 ON THE  
 LIST OF  
 DECEASED  
 PERSONS  
 IN THE  
 CITY OF  
 BALTIMORE

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH.

## CERTIFICATE OF DEATH

Reg. Dist. No.

06490

6550

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				1453.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>				d. STREET ADDRESS <u>816 Coby Lane Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Albert Gross</u>				4. DATE OF DEATH Month Day Year <u>June 10, 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>January 1894</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luellen Gross</u>				14. MOTHER'S MAIDEN NAME <u>Annie ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-2165</u>		17. INFORMANT Address <u>Mrs. Smith-Social Worker-Prince George Hosp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epilepsy</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>May 16</u> , 1960, to <u>June 10</u> , 1960, that I last saw the deceased alive on <u>June 5</u> , 1960, and that death occurred at <u>3:30A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James M. Pair</u> M.D. <u>400 N. Carrollton Ave.</u> <u>June 10, 1960</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>James M. Pair, M.D.</u> <u>Baltimore 23, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)				
<u>Burial</u>	<u>6-13-60</u>	<u>Ash Memorial</u>	<u>Sandy Spring, Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE			
<u>Robert L. Anderson</u>			DATE <u>June 16 1960</u>	<u>Carlton L. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

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CERTIFICATE OF DEATH

53

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 308, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot wound of the chest		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Macon, Georgia	
10. DATE OF BIRTH January 19, 1933		11. PLACE OF BIRTH Macon, Georgia		12. OCCUPATION Attorney	
13. MARITAL STATUS Single		14. EDUCATION High School Graduate		15. RELIGION Methodist	
16. SOCIAL SECURITY NUMBER 3-015-10000		17. PREVIOUS MARRIAGES None		18. PREVIOUS DEATHS None	
19. SIGNATURE OF DECEASED James Earl Ray		20. SIGNATURE OF WITNESS John Edgar Hoover		21. SIGNATURE OF PHYSICIAN J. Edgar Hoover	
22. SIGNATURE OF CORONER J. Edgar Hoover		23. SIGNATURE OF JURY J. Edgar Hoover		24. SIGNATURE OF JUDGE J. Edgar Hoover	
25. SIGNATURE OF CLERK J. Edgar Hoover		26. SIGNATURE OF REGISTRAR J. Edgar Hoover		27. SIGNATURE OF ARCHIVIST J. Edgar Hoover	
28. SIGNATURE OF ASSISTANT ARCHIVIST J. Edgar Hoover		29. SIGNATURE OF ASSISTANT REGISTRAR J. Edgar Hoover		30. SIGNATURE OF ASSISTANT CLERK J. Edgar Hoover	

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed with the local health department and a copy sent to the State Department of Health.

2. The cause of death should be stated in as much detail as possible, and the manner of death should be stated as either natural, accidental, suicide, or homicide.

3. The place of death should be stated as either at home, in a hospital, in a nursing home, in a prison, or elsewhere.

4. The date and time of death should be stated as accurately as possible.

5. The signature of the physician or coroner must be written in ink and must be legible.

6. This certificate is to be filled out in duplicate, one copy to be filed with the local health department and the other copy to be sent to the State Department of Health.





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ALABAMA STATE DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
BIRMINGHAM, ALABAMA  
OFFICE OF THE STATE HEALTH COMMISSIONER  
BIRMINGHAM, ALABAMA  
JANUARY 1, 1912  
TO THE BOARD OF HEALTH  
BIRMINGHAM, ALABAMA  
SUBJECT: REPORT ON THE  
MORBIDITY AND MORTALITY  
DURING THE YEAR 1911  
The following table shows the  
morbidity and mortality during  
the year 1911, by month and  
sex, for the city of Birmingham,  
Alabama.

Month	Sex	Morbidity	Mortality
Jan	Male	100	5
Jan	Female	120	3
Feb	Male	110	4
Feb	Female	130	2
Mar	Male	120	3
Mar	Female	140	1
Apr	Male	130	2
Apr	Female	150	1
May	Male	140	1
May	Female	160	1
Jun	Male	150	1
Jun	Female	170	1
Jul	Male	160	1
Jul	Female	180	1
Aug	Male	170	1
Aug	Female	190	1
Sep	Male	180	1
Sep	Female	200	1
Oct	Male	190	1
Oct	Female	210	1
Nov	Male	200	1
Nov	Female	220	1
Dec	Male	210	1
Dec	Female	230	1

Total Morbidity: 2,100  
Total Mortality: 20

Respectfully,  
J. H. HARRIS,  
State Health Commissioner.

6519

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

6839

189

189



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6511

CERTIFICATE OF DEATH

66493

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 203 Eastern Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ellen Felecia HARRIS		4. DATE OF DEATH June 25 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1936
9. AGE (In years lost birthday) 23 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John William Powell		14. MOTHER'S MAIDEN NAME Helen Neal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-8751	
17. INFORMANT Address Annapolis, Md		Reginald Harris 203 Eastern Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433-0 DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Arrest. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 25, 1960, to June 25, 1960, that (I) <del>was</del> last saw the deceased alive on June 25, 1960, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Theodore H. Johnson M.D.		10:55 P.M. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. T. H. Johnson		22d. ADDRESS 37 Calvert St., Annapolis, Md.	
22b. DATE SIGNED 6/27/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-29-60	
23c. NAME OF CEMETERY OR CREMATORY Annapolis Neck		23d. LOCATION (City, town, or county) (State) Annapolis, Md	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.E. Hicks 111 Annapolis Md		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 29 1960	

CERTIFICATE OF DEATH

1951



1





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6551  
CERTIFICATE OF DEATH

06494

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patapsco Park</b>	
		d. STREET ADDRESS <b>Unknown</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John Horton</b>		4. DATE OF DEATH <b>June 24, 1960</b>	
First Middle Last		Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1896</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Hortn</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mr. Boston Welfare Worker A.A. Connty</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 31, 1958</b> to <b>June 24, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 18, 1960</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James M. Pair</b>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>June 24, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		22d. ADDRESS <b>400 N. Carrollton Ave. Balto. 23, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-27-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Law</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 28 '60</b>	
ADDRESS <b>802 Madison Ave., Balto.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

(M)

2551

CERTIFICATE OF DEATH

Name of deceased: John Jackson Sex: Male Date of birth: 1898

Place of birth: Patagonia Park Date of death: 1955

Place of death: Patagonia Park Cause of death: Heart disease

Signature of physician: John Jackson Date: 1955

Signature of registrar: John Jackson Date: 1955

Signature of informant: John Jackson Date: 1955

Signature of witness: John Jackson Date: 1955

Signature of official: John Jackson Date: 1955

Signature of official: John Jackson Date: 1955

Signature of official: John Jackson Date: 1955

Signature of official: John Jackson Date: 1955

Signature of official: John Jackson Date: 1955

Signature of official: John Jackson Date: 1955

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6512

## CERTIFICATE OF DEATH

06495

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>19 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Box-386</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Marie</u> Last <u>HOWARD</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1960</u>
9. AGE (In years lost birthday) yrs. <u>19</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Edward HOWARD</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Alice BELT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x</u> DUE TO <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>                    </u> (c) DUE TO <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>                    </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <u>                    </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>May 29, 1960</u> to <u>June 16, 1960</u> , that (1) (we) lost the deceased alive on <u>June 16, 1960</u> , and that death occurred at <u>11:50A.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Stuart H. Walker</u>		22b. DATE SIGNED <u>17 June 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stuart H. Walker</u>		22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-18-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>		23d. LOCATION (City, town, or county), (State) <u>Chesterfield, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Anna, Md</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 21 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>                    </u>			

2063355XV0

STATE OF TEXAS

1912

COUNTY OF DALLAS

WARRANT

FOR THE ARREST OF

JOHN W. BROWN

ON A CHARGE OF

VIOLATION OF

THE PROHIBITION LAWS

OF THE STATE

AND FOR THE

RECOVERY OF

FINES AND COSTS

INCURRED BY HIM

IN VIOLATION OF

THE LAWS

OF THE STATE

AND FOR THE

RECOVERY OF

FINES AND COSTS

INCURRED BY HIM

IN VIOLATION OF

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INCURRED BY HIM

IN VIOLATION OF

THE LAWS

OF THE STATE

AND FOR THE

RECOVERY OF

## CERTIFICATE OF DEATH

Reg. Dist. No. 66496

6552

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N/A Md.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade, Md</u>				c. LENGTH OF STAY IN 1b <u>1 hr 50 mi</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. ARMY HOSPITAL</u>				d. STREET ADDRESS <u>6804 Washington Blvd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>DAVID</u> Last <u>HOWELL JR</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <u>N/A</u> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 June 60</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours		Mins. <u>1</u> <u>50</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>FGGM, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Harry D. Howell</u>				14. MOTHER'S MAIDEN NAME <u>Wilma Becker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
INFORMANT <u>Mother</u>				Address <u>6804 Washington Blvd Elkridge, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>-</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>				20f. (City or town) (County) (State) <u>-</u>			
21. I certify that I attended the deceased from <u>4 June</u> , 19 <u>60</u> , to <u>4 June</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4 June</u> , 19 <u>60</u> , and that death occurred at <u>8:22P</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>USA Hospital Ft Geo G Meade, Md</u> DATE SIGNED <u>4 June 60</u>							
ACTUAL SIGNATURE <u>George N. Schultz</u>				M.D. <u>USA Hospital Ft Geo G Meade, Md</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE N. SCHULTZ, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6 June 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laboratory, U.S. Army Hospital, Ft Geo G. Meade, Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>-</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Capt. M. S. Ellis</u>				ADDRESS <u>B.M. Ellis</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRAL AIR FORCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6513  
CERTIFICATE OF DEATH

06497

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Murray</u> Last <u>HUNT</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 28, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Smith Hunt</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Faye Peake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. R. Murray Hunt</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>422.1</u> DUE TO (b) <u>Acute Congestive Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>arteriosclerosis C.O.P.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>2 wks.</u> <u>7.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12:55</u> to <u>6:20</u> , that (I) <u>did</u> last saw the deceased alive on <u>6-1-60</u> and that death occurred at <u>5:56 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Shipley</u>		22b. DATE SIGNED <u>6/3/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 6, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard O. Hardisty, Salisbury</u>		25. REC'D BY REGISTRAR DATE <u>JUN 7 60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

CERTIFICATE OF DEATH

1913



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06498

6553

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLER BARNIE</u>		c. LENGTH OF STAY IN 1b <u>15 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 Central Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARVIN</u> Middle <u>S.</u> Last <u>JEFFREY</u>		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11-1904</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A.C. Police Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A.C. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George JEFFREY (dec.)</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wade (dec.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-38-0342</u>	
17. INFORMATION <u>1223 Southview Rd Baltimore, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Calcio - Rupture</u> DUE TO (c) <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Two</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Two</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>50</u> , to <u>June 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>60</u> , and that death occurred at <u>7:10 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Bellingsh</u> M.D.		ADDRESS (Street, city or town, state) <u>108 Central Ave Glen Burnie Md</u> DATE SIGNED <u>June 27, 1960</u>	
PHYSICIAN'S NAME (Type) <u>James S. Bellingsh</u>		<u>108 Central Ave Glen Burnie Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-29-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Epishany chmrs</u>	22d. LOCATION (City, town, or county) (State) <u>Odenton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home - Robert P. Little</u>		24a. REC'D BY REGISTRAR <u>Stan Barnes</u> DATE <u>JUN 30 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

1997

## CERTIFICATE OF DEATH

Reg. Dist. No.

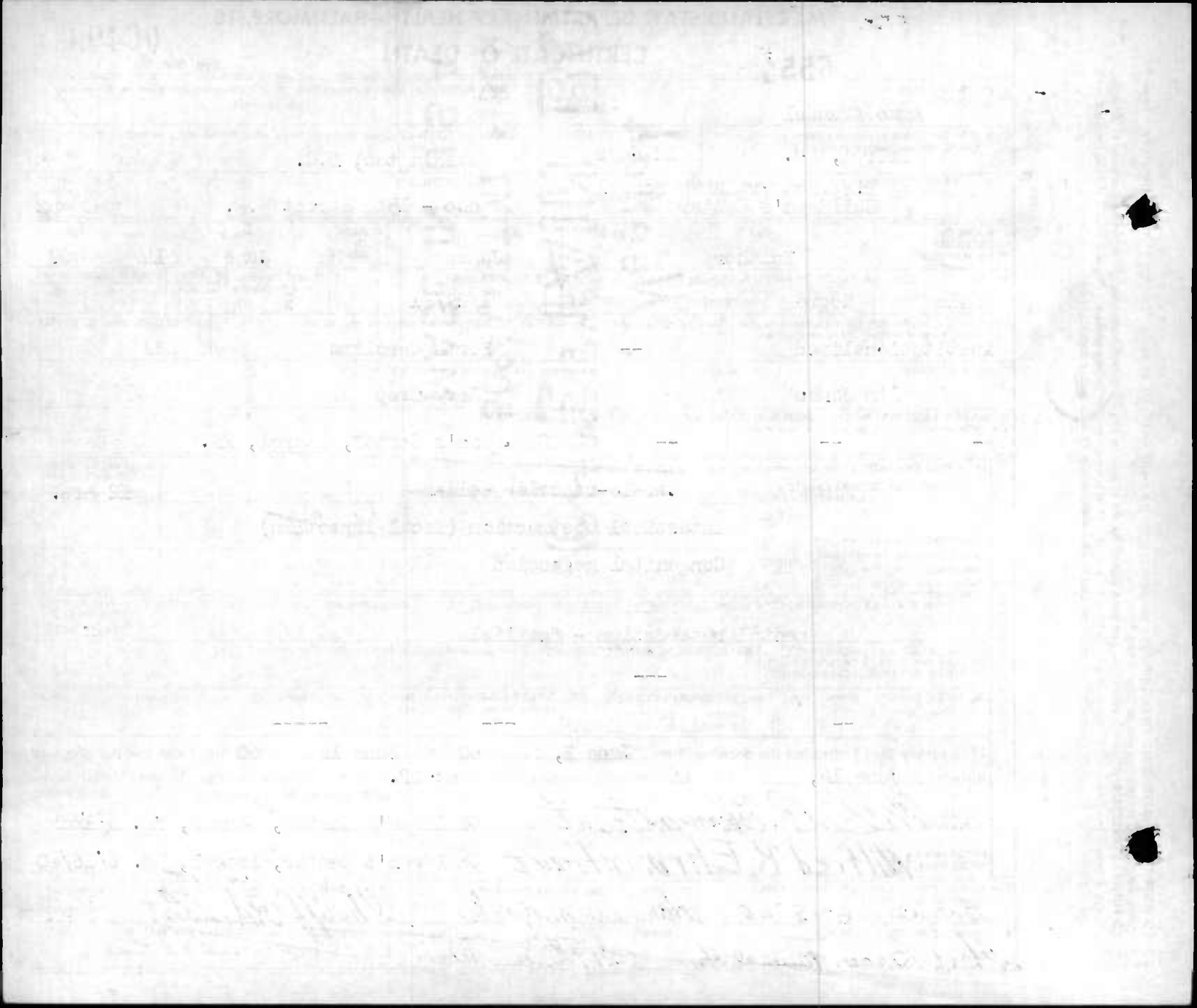
06499

6554

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>District Training School Children's Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Keither</u> Middle _____ Last <u>Jones</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/29/51</u>
9. AGE (In years last birthday) <u>9</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>institutionalized</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jim Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Children's Center, Laurel, Md.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular collapse</u> <u>756.2</u> DUE TO <u>Intestinal obstruction (fecal impaction)</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Congenital megacolon</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mental retardation - familial</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>June 2,</u> 19 <u>60</u> , to <u>June 14,</u> 19 <u>60</u> , that I last saw the deceased alive on <u>June 14,</u> 19 <u>60</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D. <u>Children's Center, Laurel, Md. 6/16/60</u> PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut</u> <u>Children's Center, Laurel, Md. 6/16/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harmory M. Jones</u>	22d. LOCATION (City, town, or county) <u>Sherrill Rd. St.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Brown</u> ADDRESS <u>Funeral Home 6217 E. Ave. N.E.</u>		24a. REC'D BY REGISTRAR <u>JUN 20 1960</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





06560

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>		c. LENGTH OF STAY IN 1b <i>5 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Pasadena RFD</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4-3-Duval Hwy (Green Haven)</i>				d. STREET ADDRESS <i>4-3 Duval Hwy. (Green Haven)</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John</i>		First <i>John</i>		Middle <i>Lee</i>		Last <i>Jubb St.</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11 Apr. 1896</i>	
				9. AGE (In years last birthday) <i>64 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sub f. (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Balto. Gas Elec. Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Jubb</i>				14. MOTHER'S MAIDEN NAME <i>(unknown) Leidner</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>212056554</i>		17. INFORMANT <i>Mrs. Elizabeth C. Jubb</i>			
						Address <i>Sam Houston</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the stomach</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>June 2, 1960</i> , to <i>June 21, 1960</i> , that I last saw the deceased alive on <i>June 20, 1960</i> , and that death occurred at <i>6:00 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>				ADDRESS (Street, city or town, state) <i>Pasadena, Md.</i>			
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>				DATE SIGNED <i>June 21, 1960</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>24 June 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Balto. Nat'l. Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. D. Kingston</i>				ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 27 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 6514  
 CERTIFICATE OF DEATH

06501

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Severn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Lee</b> Last <b>KIESSLING</b>				4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1960</b>		9. AGE (In years last birthday) yrs. <b>47</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>47</b>	IF UNDER 24 HRS. Min. <b>47</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Wilbert Vernon Kiessling</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Rahnis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Hospital records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACRANIAL HEMORRHAGE</b> DUE TO <b>BLEECH DELIVELY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BLEECH DELIVELY</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 29, 1960</b> to <b>June 30, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 30, 1960</b> , and that death occurred at <b>9:30 P.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Stuart H. Walker</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>June 30, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stuart H. Walker</b>				22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>July 1, 60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blm Haven</b>		23d. LOCATION (City, town, or county) (State) <b>Blm Haven Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard G. Fomic</b>				25a. REC'D BY REGISTRAR <b>5 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kneass</b>	

2063344XV6

CERTIFICATE OF DEATH

STATE OF NEW YORK  
COUNTY OF [illegible]

[Illegible text, likely a form for a death certificate, including fields for name, date, and cause of death.]

6556  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write <b>Ft George G Meade, Md</b> ) c. LENGTH OF STAY IN lb <b>18 Hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write <b>RURAL</b> and give nearest town) <b>Dorsey, Road Elkridge, Maryland</b> d. STREET ADDRESS <b>Route 4 Box 236</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Doris</b> <b>Annette</b> <b>Kitzmiller</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1960</b>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Teddy William Kitzmiller</b>	
14. MOTHER'S MAIDEN NAME <b>Madeline Kane</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT (Father) <b>Teddy W. Kitzmiller</b> Address <b>Dorsey Rd Elkridge, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>776 X</b> IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>Henry N. Claman</b> deceased from <b>6:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>22 June 60</b>			
ACTUAL SIGNATURE <b>Henry N. Claman</b> M.D.		DATE SIGNED <b>22 June 60</b>	
PHYSICIAN'S NAME (Type) <b>Henry N. Claman Captain, MC</b>		U.S. Army Hospital Ft George G Meade, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>23 June 60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Howard - Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert P. Curran - Glen Burnie, Md</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 27 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050171XV0

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1922



1





TO HOSPITAL: 3. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
6515

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06503

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William H. Knowles</u>		4. DATE OF DEATH <u>June 3, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 30, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W<sup>M</sup> HAZARD KNOWLES</u>		14. MOTHER'S MAIDEN NAME <u>ANNA ELIZABETH FRANTUM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>ROSA VIRGINIA KNOWLES #2</u>	
17. INFORMANT Address <u>ROSA VIRGINIA KNOWLES #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amnesia</u> <u>463X</u> DUE TO <u>Cerebral Vascular Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Thrombophlebitis, left leg</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>without structure</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-31-60</u> to <u>6-3-60</u> that (I) (we) last saw the deceased alive on <u>6-3-60</u> and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M Shipley</u>		22b. DATE SIGNED <u>6-7-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Frank Shipley</u>		22d. ADDRESS <u>Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-6-1960</u>		23b. DATE THEREOF <u>Cedar Bluff</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Annapolis</u>		23d. LOCATION (City, town, or county) (State) <u>MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 7 '60</u>	
ADDRESS <u>SON ANNAPOLIS MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

STATE OF TEXAS  
COUNTY OF DALLAS

1915

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1915

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6516 CERTIFICATE OF DEATH

06504

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Solomons</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>04X-2</b>	
3. NAME OF DECEASED (Type or print) First <b>Charlotte</b> Middle <b>Ann</b> Last <b>LANKFORD</b>		4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1960</b>
9. AGE (In years lost birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>35</b> Hours <b>35</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Roland Eugene LANKFORD</b>		14. MOTHER'S MAIDEN NAME <b>Gloria Elaine WEBSTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>752X</b> IMMEDIATE CAUSE (a) <b>Advanced hydrocephalus + Meningomyelocoele</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 23, 1960</b> to <b>June 23, 1960</b> , that (I) <del>last</del> saw the deceased alive on <b>June 23, 1960</b> , and that death occurred at <b>2:20A.</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>James I. Hudson, Jr.</b>		22b. DATE SIGNED <b>24 June 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>James I. Hudson, Jr.</b>		22d. ADDRESS <b>River Club Estates, Edgewater, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 25, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Solomons Methodist Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Solomons - Calvert Co. - Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>A.A. Henderson &amp; Son - Michael, Inc.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 28 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6517  
CERTIFICATE OF DEATH

06505

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>M</u> Last <u>LOCKETT</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1896</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Diesel Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USGOV. (Test)</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thaddeus Lockett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Britton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>214 05 4023</u>	
17. INFORMANT <u>Mrs Annie J. Lockett- Wife- Same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS,</u> <u>10 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 12 59</u> to <u>June 6, 19 60</u> , that (I) (we) last saw the deceased alive on <u>June 6, 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u>		22b. DATE SIGNED <u>6/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>		22d. ADDRESS <u>71 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 9, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 10 '60</u>	
ADDRESS <u>Annapolis, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawe</u>	

CERTIFICATE OF DEATH

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23 April 1944

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1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 25 Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>				d. STREET ADDRESS <b>242 Zeppelin Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Thomas</b>		Last <b>Luster</b>		4. DATE OF DEATH Month <b>June 7,</b> Day <b>1960</b> Year <b>19</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-29-1892</b>	
9. AGE (In years lost today) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b>		IF UNDER 24 HRS. Days <b>68</b>		Hours <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dock hand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Luster</b>				14. MOTHER'S MAIDEN NAME <b>Ida Walker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Leo Boston-A.A.Co. D.P.W.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1960</b> to <b>June 7, 1960</b> that (I) (we) last saw the deceased alive on <b>June 5, 1960</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James M. Pair</b>				22b. DATE <b>June 8, 1960</b>		22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>	
22d. ADDRESS <b>400 N. Carrollton Ave. Balto. 23, Md.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE <b>June 8, 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-10-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b> ADDRESS <b>802 Madison Avenue</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

6518

06562

1. PLACE OF DEATH o. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hosp.</u>				d. STREET ADDRESS <u>1 Pasadena Rd - Ventnor</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>F.</u> Last <u>Marshall</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7 April 1895</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>1960</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Neithaus</u>				14. MOTHER'S MAIDEN NAME <u>Frances Ballhorn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Lenore F. Inman</u> Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4:20 P.M.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March</u> , 1960, to <u>June 2</u> , 1960, that I last saw the deceased alive on <u>May 27</u> , 1960, and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>				ADDRESS (Street, city or town, state) <u>Mountain Rd. Rt #8</u> DATE SIGNED <u>6/2/60</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>				<u>Pasadena, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6 June 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemo</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 8 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



THIS IS A PERMANENT RECORD.  
EWM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.  
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. NAME OF DECEASED  
(Type or Print)

65538

ELLA MILLER

2. DATE OF DEATH

06568  
6-15-60

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

5931 BELLE GROVE Rd

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND A.A. County

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

50 BALTIMORE - 25

D. STREET ADDRESS

(If rural, give location)

1 5931 BELLE GROVE Rd.

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

8-3-1877

9. AGE (In years  
last birthday)

82

If Under 1 Year

If Under 24 Hours

Months

Days

Hours

Min.

10. A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even  
if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

SPENCER PATRICK

14. MOTHER'S MAIDEN NAME

BETTY FITZGERALD

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

VIOLA MILLER 5931 BELLE GROVE Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

420.1

(A) \_\_\_\_\_  
DUE TO

MYOCARDIAL INFARCTION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO

ARTERIOSCLEROTIC  
CARDIOVASCULAR DIS.

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II  
OF INJURY (Month) (Day) (Year)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐

NO ☒

21A. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21B. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

JUNE 15 1960

that (I) (we) last saw the deceased alive on

FEB. 9, 1959  
JUNE 6 1960

and that in (my) (our) opinion death occurred at

4 A.M.

from the causes and on the date stated above.

23A. SIGNATURE

John B. Smith Jr.

23B. ADDRESS

922 S. Hay

23C. DATE SIGNED

6/15/60

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

REMOVAL 6-25-60

ALTAVISTA CEM.

ALTAVISTA, VIRGINIA

25A. NAME OF REGISTRAR

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUN 17 1960

Isaiah L. Brown & Son

Isaiah L. Brown & Son





## CERTIFICATE OF DEATH

Reg. Dist. No.

6559

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____ <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>24 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> <b>47X-3</b>			
d. NAME OF HOSPITAL, HOME, OR INSTITUTION <b>District Training School Children's Center</b>				d. STREET ADDRESS <b>6912 Willow Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle _____ Last <b>Nesbitt</b>			4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 60</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1921</b>		9. AGE (In years last birthday) yrs. <b>39</b>	10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>institutionalized</b>		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert H. Nesbitt</b>				14. MOTHER'S MAIDEN NAME <b>Ida Bills</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---		INFORMANT Address <b>Children's Center, Laurel, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration - pneumonia</b> DUE TO <b>Lung abscess</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Spastic quadriplegia - mental retardation</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>6/19/36</b> , 19____, to <b>6/13/60</b> , 19____, that I last saw the deceased alive on <b>6/13/60</b> , 19____, and that death occurred at <b>9:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>James E. Boyland</b> M.D. <b>Children's Center, Laurel, Md.</b> PHYSICIAN'S NAME (Type) <b>James E. Boyland</b> <b>Children's Center, Laurel, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>June 16, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON NATL VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>254 Carroll St. Wash, D.C.</b>				24a. REC'D BY REGISTRAR <b>JUN 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

CERTIFICATE OF DEATH

255



Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The text is mirrored and faint, suggesting a bleed-through from the reverse side of the page.

6560

## CERTIFICATE OF DEATH

Reg. Dist. No. 06510

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lake Shore, Pasadena</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lake Shore, Pasadena, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RE-10 Box 337-A, Pasadena.</u>				d. STREET ADDRESS <u>Alvin Rd., Lake Shore, Pasadena, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GRACE</u> First <u>R.</u> Middle <u>O'HARA</u> Last				4. DATE OF DEATH <u>June</u> Month <u>25</u> Day <u>1960</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1914</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Tanger Island, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Edward Payne (dec.)</u>				14. MOTHER'S MAIDEN NAME <u>Viola Crockett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-04-8777</u>			
17. INFORMANT <u>Mrs. Grace O'Hara</u> Address <u>Lake Shore, Pasadena, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of rectum</u> DUE TO (c) <u>Rheumatic heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 23, 1960</u> to <u>June 25, 1960</u> , that I last saw the deceased alive on <u>June 24, 1960</u> , and that death occurred at <u>3:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmond I. Moushabeck</u> M.D.				ADDRESS (Street, city or town, state) <u>21015, Ritchie Highway, Glen Burnie, Md.</u>			
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u>				DATE SIGNED <u>6/25/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-26-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fredens, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home - Robert Ware</u> ADDRESS <u>Glen Burnie</u>				24a. REC'D BY REGISTRAR <u>June 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Talbot</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNEAPOLIS-MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLIFORD-</u> <u>20X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A.-ANNE ARUNDEL-General.</u>		d. STREET ADDRESS <u>Box 95.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stewart</u> Middle <u>REDEFIELD</u> Last <u>PARKER.</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/14</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Accountant</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stewart P. Parker</u>		14. MOTHER'S MAIDEN NAME <u>Emily Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>Yes</u> <u>U.S. Army</u>		16. SOCIAL SECURITY NO. <u>089-12-5883</u>	
17. INFORMANT <u>Mr. Maurice Parker</u>		Address <u>Oxford Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>6-10-60</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/12/60</u>	22b. DATE THEREOF <u>6/12/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Rectory</u>	22d. LOCATION (City, town, or county) (State) <u>Easton</u> <u>Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Cook</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 14 '60</u>	
ADDRESS <u>Easton Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 NEW YORK STATE DEPARTMENT OF HEALTH-BUFFALO 18

M

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____		TIME OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
PLACE OF DEATH _____		DATE OF DEATH _____		TIME OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF CORONER _____		SIGNATURE OF JURY _____	
OFFICE OF MEDICAL EXAMINER _____		OFFICE OF CORONER _____		OFFICE OF JURY _____	

BUFFALO  
 18



6520

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>4 hr 8 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital, Annapolis, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Phillip</u> Middle <u>Edgar</u> Last <u>PETERSON</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30th</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-30-60</u>	
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>4</u> Min. <u>8</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Richard Dale PETERSON</u>				14. MOTHER'S MAIDEN NAME <u>Alyce Jean SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. -----			
17. INFORMANT <u>Father - 28 Badger Road, Annapolis, Maryland</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pre-maturity &amp; APLASIA</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 hr - 8 min</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from <u>12:47PM 6/30 1960</u> to <u>4:55PM 6/30 1960</u> that I last saw the deceased alive on <u>30 June</u> 19 <u>60</u> , and that death occurred at <u>4:55P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>1 July 60</u>							
ACTUAL SIGNATURE <u>I. C. MAZZARELLA</u> M.D.				DATE SIGNED <u>1 July 60</u>			
PHYSICIAN'S NAME (Type) <u>I. C. MAZZARELLA, LT MC USN</u>				U. S. Naval Hospital, Annapolis, Maryland			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial July 5 1960</u>				22b. DATE THEREOF <u>July 5 1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor - Sons</u>				ADDRESS <u>Annapolis Md</u>			
24a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051242XV3



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6561

CERTIFICATE OF DEATH

Reg. Dist. No.

06513

1. PLACE OF DEATH o. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>AA.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sherwood Forest</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Sherwood Forest</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>325 Clapston Hill</i>				d. STREET ADDRESS <i>325 Clapston Hill</i>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>M.</i> Last <i>Pfautz Jr.</i>				4. DATE OF DEATH Month <i>6-</i> Day <i>27</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-3-1905</i>		9. AGE (In years lost birthday) <i>55</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales manager</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retail Sales</i>		11. BIRTHPLACE (State or foreign country) <i>Pittsburg Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John M. Pfautz Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Harriett Reed Howell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>160-01-9431</i>		17. INFORMANT <i>Margaret H. Pfautz</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxiation</i> DUE TO <i>Cancer, Lung, Metastatic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cancer, Lung</i> (c) <i>Cancer, Lung</i>							INTERVAL BETWEEN ONSET AND DEATH <i>22 Nov.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Marion</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>25 May</i> , 19 <i>60</i> , to <i>2 June</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>25 June</i> , 19 <i>60</i> , and that death occurred at <i>4:30 A.</i> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Wm. P. Stephens</i>				ADDRESS (Street, city or town, state) <i>38 Cornhill Annapolis Md.</i>			
DATE SIGNED <i>June 30 1960</i>							
PHYSICIAN'S NAME (Type) <i>John M. Saylor Sons</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-29-1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Annes Cemt</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons</i>				24. REC'D BY REGISTRAR DATE <i>JUN 30 1960</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be read by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

6521

06514

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>11 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>911 CENTRAL ST.</u>							
3. NAME OF DECEASED (Type or print) First <u>LEANDER</u> Middle <u>Phelps</u> Last <u>Phelps</u>				4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>19 60</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 17-93</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u> Hours <u>19</u> Min. <u>60</u>		IF UNDER 24 HRS. Months <u>6</u> Days <u>11</u> Hours <u>19</u> Min. <u>60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bldg. Attendant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS-Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Phelps</u>				14. MOTHER'S MAIDEN NAME <u>ANNA BOOZE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>219-16-0660A</u>			
17. INFORMANT <u>Maude-Phelps-911 CENTRAL ST.</u>				Address <u>ANNAPOLIS-Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/25/1955</u> , to <u>6/11/1960</u> , that I last saw the deceased alive on <u>6/11/1960</u> , and that death occurred at <u>8:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson, Jr.</u>				ADDRESS (Street, city or town, state) <u>Cinnaph, Md.</u>			
DATE SIGNED <u>6/13/60</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-17-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.S. NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS-Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks III</u>				ADDRESS <u>ANNAPOLIS-Md.</u>			
24a. REC'D BY REGISTRAR <u>—</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			
DATE <u>JUN 21 '60</u>							

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6522

## CERTIFICATE OF DEATH

06515

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul A. Pohlner</u>		4. DATE OF DEATH <u>June 12</u> 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1901-Oct-4th</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Shipbuilding Drydock</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Louis R. Pohlner</u>		14. MOTHER'S MAIDEN NAME <u>Anne Hoyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-4590</u>	
17. INFORMANT <u>Mrs. A. Paul Pohlner</u>		Address <u>Box 313 Severna Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>410X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 10</u> , 19 <u>58</u> , to <u>June 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 7</u> , 19 <u>60</u> , and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6-13-60</u> ACTUAL SIGNATURE <u>Ray M. Smith M.D.</u> PHYSICIAN'S NAME (Type) <u>Dr. Robert Hahn</u> <u>Severna Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>15 June</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Slighter</u>		24. REC'D BY REGISTRAR <u>JUN 15 '60</u>	
ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

# CERTIFICATE OF DEATH

<p>1. Name of Deceased: <u>JOHN DOE</u></p>		<p>2. Date of Death: <u>10-15-1968</u></p>	
<p>3. Place of Birth: <u>NEW YORK, N.Y.</u></p>		<p>4. Age at Death: <u>45</u> Years</p>	
<p>5. Sex: <u>Male</u></p>		<p>6. Race: <u>White</u></p>	
<p>7. Marital Status: <u>Married</u></p>		<p>8. Occupation: <u>Teacher</u></p>	
<p>9. Cause of Death: <u>Heart Disease</u></p>		<p>10. Place of Death: <u>Home</u></p>	
<p>11. Signature of Physician: <u>[Signature]</u></p>		<p>12. Signature of Registrar: <u>[Signature]</u></p>	
<p>13. Date of Issuance: <u>10-16-1968</u></p>		<p>14. Office of Registrar: <u>New York City</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06516

6562

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>8 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>600 Balto.-Annap. Road, Ferndale</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>60 Glen Burnie</b> d. STREET ADDRESS <b>600 Balto.-Annap. Road, Ferndale</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alice Lehr Pumphrey</b>		4. DATE OF DEATH Month Day Year <b>June 4th 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16th Dec. 1868</b>
9. AGE (In years last birthday) <b>91 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework (ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Rider</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Merritt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Cora E. Kelly, Same as #No. 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO <b>434.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Edema</b> DUE TO <b>Congestive Heart Failure</b> (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 min</b> <b>10 days</b> <b>8 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/10</b> , 19 <b>52</b> to <b>6/3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/3</b> , 19 <b>60</b> , and that death occurred at <b>8 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>715 - COTTER Rd Glen Burnie, Md</b> DATE SIGNED <b>6/6/60</b>			
ACTUAL SIGNATURE <b>R. W. Prichard</b>		M.D. <b>715 - COTTER Rd Glen Burnie, Md</b>	
PHYSICIAN'S NAME (Type) <b>R. W. Prichard</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7 June 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Anne Arundel, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Singleton</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>JUN 8 '60</b>	



# CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6523

06517

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>PUMPHREY</b> Last <b>PUMPHREY</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 28, 1900</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Transportation (ret.)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Emp.</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Addison Pumphrey</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-32-9181</b>			
17. INFORMANT <b>Mr. Wm. Pumphrey</b>				Address <b>Odenton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Ac &amp; Ch. Congestive Failure</b> DUE TO (c) <b>Diabetes m.</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>6 min</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes m.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>4:20A.</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>				20f. (City or town) <b>—</b> (County) <b>—</b> (State) <b>—</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>June 11, 1960</b> , to <b>June 12, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 12, 1960</b> , and that death occurred at <b>4:20A.</b> M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank M. Shipley</b>				22b. DATE SIGNED <b>4:20A.</b>			
22c. PHYSICIAN'S NAME (Type) <b>Frank M. Shipley</b>				22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>16 June 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Ch. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Odenton, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. K. Dumbarton</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 15 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Glen Burnie, Md.</b>							

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CERTIFICATE OF DEATH

100

100

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# CERTIFICATE OF DEATH

06518

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/58

may be referred by the hospital or attending physician:

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED FROM THE OFFICE OF THE SECRETARY OF THE ARMY

100-100

OFFICE OF THE SECRETARY OF THE ARMY

100-100



(100-100)

100-100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6524

06519

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8 Pinkney St.</u>		d. STREET ADDRESS <u>18 Pinkney St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>C.</u> Last <u>Queen</u>		4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Barker</u>	14. MOTHER'S MAIDEN NAME <u>Annabida Pope</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Allan Queen - Annapolis, Md.</u> Address <u>  </u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-4-59</u> 19 <u>  </u> to <u>6-22-60</u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>6-17-60</u> 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>A. T. Allen</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		22d. ADDRESS <u>62 Oakchapel St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-25-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>  </u> DATE <u>JUN 24 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6564

Reg. Dist. No. 16520

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b> c. LENGTH OF STAY IN 1b <b>13 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4935 Brookwood Road.</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>50 Same</b> d. STREET ADDRESS <b>Same</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Paul Leroy Redden</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19th</b> Year <b>19 60</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/3/02</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.	IF UNDER 24 HRS. Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance man at Hoschild Kohn</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Norfolk, Va.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		
13. FATHER'S NAME <b>Herman Redden</b>			14. MOTHER'S MAIDEN NAME <b>Bessie Moore</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>National Guard 21 Years</b>		16. SOCIAL SECURITY NO. <b>217-07-9532</b>		17. INFORMANT <b>Mrs. Edith Mae Redden (wife)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Brooklyn, Md.</b>	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>6/19/60</b>		
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/23/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) <b>Brooklyn, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes</b>			ADDRESS <b>130 E. Fort Ave., Balt.</b>		24a. REC'D BY REGISTRAR <b>JUN 22 '60</b>		
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose it in a separate envelope, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH - CALIFORNIA  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		INJURY		TOXIC	
SIGNED AND SEALED		MEDICAL EXAMINER		JURY		CORONER		PROSECUTOR		DEFENSE		JUDGE	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.		DIVISION OF IDENTIFICATION		LABORATORY		FINGERPRINTS		PHOTOGRAPHY	
REMARKS		TESTS		TREATMENT		HISTORY		FAMILY		SOCIAL		RELIGIOUS	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		BY WHOM EXAMINED		WITNESSES		SIGNATURE		STAMP	

14

14



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6565

06521

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>			c. LENGTH OF STAY IN 1b <b>6 yrs. 1 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3401.4</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>3116 Barclay Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Abdul</b> Middle Last <b>Rezar</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1894?</b>		9. AGE (In years last birthday) yrs. <b>66?</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, (if any, which gave rise to immediate cause (a), stating the under-lying cause lost.) (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>-----</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic Reaction, Paranoid Type</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>-----</b> 19 <b>-----</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 23, 1954</b> to <b>June 23, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 23, 1960</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Hildegard H. Reissmann</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>June 24, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Hildegard H. Reissmann</b>				22d. ADDRESS <b>Crownsville State Hospital, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6.28.1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Kneass</b>				25a. REC'D BY REGISTRAR <b>DATE JUN 29 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>	

MEDICAL CERTIFICATION

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

doi:10.1017/S0022292412001619

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06522

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Annapolis</u>		c. LENGTH OF STAY IN 1b <u>15 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mill Creek, 10 feet of the shore.</u>				d. STREET ADDRESS <u>Brownwood Rd. Route 4</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Warren Paul Ridge</u>				4. DATE OF DEATH Month Day Year <u>June 1st. 19 60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/23/57</u>		9. AGE (In years last birthday) <u>3</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Glen Burnie, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Ridge</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mae Pumphrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William Ridge (father)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning</u> <u>850 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off a row boat into 4 feet of water.</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:30 P.M. 6/1/60 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Mill Creek</u>		20f. (City or town) (County) (State) <u>P.O. Annapolis, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/1/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4 June 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware - Glen Burnie</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with this certificate. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

<p align="center"><b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p>											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adenton Oakland</b> d. STREET ADDRESS <b>1</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Severn River</b>				c. LENGTH OF STAY IN 1b				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>City Dock, Annapolis</b>											
3. NAME OF DECEASED (Type in full) <b>Carl Perry Jamison Rine</b> (Also known as <b>Ded</b> )				4. DATE OF DEATH Month <b>June</b> Day <b>24<sup>th</sup></b> Year <b>1960</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 25, 09</b>		9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Road man</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>A. A. Co. Md</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>Wormes Rine</b>				14. MOTHER'S MAIDEN NAME <b>Johnson Nellie Methkin</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>Archie Mae Rine</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? (partial) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Boat overturned--unable to swim</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>6</b> p.m. <b>6/25/60</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Severn River</b>		20f. (City or town) <b>Annapolis</b>		(County) <b>Anne Arundel</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>June 26, 1960</b>			
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>June 26<sup>th</sup> 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial</b>		22d. LOCATION (City, town, or country) (State) <b>Annapolis Md</b>			
23. FUNERAL DIRECTOR <b>John W. Taylor Sons</b>				ADDRESS <b>Annapolis Md</b>				24a. REC'D BY REGISTRAR <b>JUN 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Figure 1

⑤



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6568 CERTIFICATE OF DEATH 06525

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>1 year 10mo. 25 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Unknown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Italy</b> Middle <b>Anthony</b> Last <b>Robinson</b>				4. DATE OF DEATH Month <b>6</b> Day <b>5</b> Year <b>1960</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 19, 1876</b>		9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b> Hours <b>16</b> Min. <b>16</b>		11. IF UNDER 24 HRS. Hours <b>16</b> Min. <b>16</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Pampey Robinson</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hemorrhage</b> DUE TO <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>44-EX</b> (c) <b>44-EX</b>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic gastric ulcer with bleeding</b>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>											
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>-----</b> p. m. <b>-----</b> 19 <b>6/5</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>7/10/1958</b> to <b>6/5/1960</b> , that (I) (we) last saw the deceased alive on <b>6/5/1960</b> , and that death occurred at <b>4:35 P.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Hildegard Heard Reissman</b>						22b. DATE SIGNED <b>6/6/60</b>									
22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>						22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-8-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville State Hosp.</b>				23d. LOCATION (City, town, or county) (State) <b>Crownsville, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Ward</b>						25a. REC'D BY REGISTRAR <b>JUL 1 '60</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

CERTIFICATE OF DEATH

1922

1

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

ETHNICITY

DATE OF BIRTH

PLACE OF BIRTH

UNKNOWN

DATE OF DEATH

1

SEX

AGE

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CHIEF

DATE

PLACE

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06526

Reg. Dist. No. 06526

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Old Annapolis Road</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Hanford</i> Middle <i>L.</i> Last <i>Sarles</i>		4. DATE OF DEATH Month <i>6</i> Day <i>6</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-11-1899</i>
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>6</i>	IF UNDER 24 HRS. Hours <i>19</i> Min. <i>60</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mr. Midshipman Store U.S. Naval Academy</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Oxford Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>N. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>N. S. A.</i>	
13. FATHER'S NAME <i>Benjamin E. Sarles</i>		14. MOTHER'S MAIDEN NAME <i>Grace M. Redden</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Florence L. Sarles</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.4</i> <i>Cardiac disease</i> DUE TO <i>Sudden</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>434.4</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. L. Wharfed</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. Wharfed</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-9-1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cent</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>JUN 10 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	



# CERTIFICATE OF DEATH

Reg. Dist. No.

06527

6570

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>320 Church Circle</u>		e. STREET ADDRESS <u>320 Church Circle</u>	
3. NAME OF DECEASED (Type or print) <u>Katie</u> First <u>Schilling</u> Middle <u>berg</u> Last		4. DATE OF DEATH <u>June 10</u> Month <u>June</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1884</u> 9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>? Doerr</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Schmidt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT <u>Mildred C. Smith 320 Church Circle Md.</u> Address <u>Linthicum Hgts.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>422.1</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>59</u> , to <u>Jun 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jun 10</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>108 Cedar on Glen Burne Rd. Baltimore, Md.</u> DATE SIGNED <u>Jun 11, 1960</u>			
ACTUAL SIGNATURE <u>James S. Bellinger</u>		M.D. <u>108 Cedar on Glen Burne Rd. Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James S. Bellinger</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> ADDRESS <u>4107 Wilkens Avenue</u>		24a. REC'D BY REGISTRAR <u>JUN 14 '60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dis. No. 06528

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Own Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Fitzhue (Fritz)</u> <u>Lee</u> <u>Sears</u> First Middle Last				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>28</u> Year <u>1960</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 6, 1885</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Anne Arundel Co.,</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Unknown John Wesley Sears</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown Mary Elizabeth Phipps</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>213-18-6467</u>				<b>17. INFORMANT</b> Address <u>Raymond B. Sears, same as 2</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> <u>Personary Occlusion</u> IMMEDIATE CAUSE (a) <u>Personary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>															
<b>ACTUAL SIGNATURE</b> <u>G. H. Faubert</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>G. H. Faubert, M.D.</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>6/29/60</u> <b>DATE SIGNED</b>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>July 1, 1960</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Bluff</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Annapolis, Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hopping Funeral Home, Annapolis, Md.</u>								<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <u>DATE JUN 1 '60</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06529

Reg. Dist. No.

6572

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>9 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>614 Balto--Annap-Bldg N.E.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>1614 Balto-Annap.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Neuk O. Shea</u>		4. DATE OF DEATH <u>June 16, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 March 1895</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pascoag, Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Stuart</u>		14. MOTHER'S MAIDEN NAME <u>Octavia Burton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Geraldine Kearns</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Dis.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1952</u> to <u>June 1960</u> that I last saw the deceased alive on <u>6-15-60</u> , 19 <u>60</u> , and that death occurred at <u>4:40</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles R. McDonald</u> M.D.		ADDRESS (Street, city or town, state) <u>204 Crain Hwy.</u>	
PHYSICIAN'S NAME (Type) <u>Charles R. McDonald</u>		DATE SIGNED <u>6-17-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>21st June 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>All Hallows Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Moosup, Conn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>20 June 60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinsie</u>	

CERTIFICATE OF DEATH

1925

ALVIN BOND  
 1000 CONTEMP  
 1000 CONTEMP

NAME OF DECEASED ALVIN BOND		SEX MALE	
AGE 35		RACE WHITE	
DATE OF DEATH JAN 10 1925		PLACE OF DEATH HOME	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE		OCCUPATION CLERK	
MARITAL STATUS SINGLE		EDUCATION HIGH SCHOOL	
RELIGION METHODIST		SIGNATURE OF DECEASED ALVIN BOND	
SIGNATURE OF WITNESS J. B. BOND		SIGNATURE OF PHYSICIAN J. B. BOND	
SIGNATURE OF CLERK J. B. BOND		SIGNATURE OF REGISTRAR J. B. BOND	

THE STATE DEPARTMENT OF HEALTH  
 1000 CONTEMP  
 1000 CONTEMP

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06530

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A.A. Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Same</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b>		c. LENGTH OF STAY IN TB <b>5 yr -</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>515 Lyman St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ida Elizabeth Shirk</b>		4. DATE OF DEATH <b>6/29/60</b> 19 <b>60</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 14 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Donestown Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mathias Shirk</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Warren Shirk - Linthicum</b>		Address <b>Linthicum</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular Disease</b> DUE TO (b) <b>Arterio-Sclerosis</b> DUE TO (c) <b>10-12 yr</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan - 1957</b> to <b>6/29</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/29/60</b> , 19 <b>60</b> , and that death occurred at <b>3 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chas. L. Ball Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Linthicum - Md</b> DATE SIGNED <b>6/29/60</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-2-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion-Emmanuel Lutheran Church</b>	22d. LOCATION (City, town, or county) (State) <b>Donestown - Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Singleton Funeral Home - Robert P. Ware</b>		24a. REC'D BY REGISTRAR <b>John Bunnie</b> DATE <b>JUL 5 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

JAMES J. JONES

Name of Deceased		JAMES J. JONES	
Date of Birth		[illegible]	
Place of Birth		[illegible]	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		[illegible]	
Cause of Death		[illegible]	
Date of Death		[illegible]	
Place of Death		[illegible]	
Signature of Physician		[illegible]	
Signature of Registrar		[illegible]	



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6525

CERTIFICATE OF DEATH

06531

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>X Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alma GROLL Simon,</u>				4. DATE OF DEATH Month Day Year <u>6- 26 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 8-1876</u>	9. AGE (In years last birthday) yrs. <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Franz Groll</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give year or dates of service)			
17. INFORMANT <u>Mrs Leonard E. Weaver</u>				Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pneumonitis</u> DUE TO <u>Inter-trochanteric fracture of left femur and proximal fracture of left humerus.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic <del>xx</del> hypertensive cardiovascular disease</u> (c) <u>Diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>13 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Oct. 10</u> , 19 <u>58</u> , to <u>June 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>60</u> , and that death occurred at <u>5:30 a</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sylvia M. Lim</u>		M.D. <u>Mayo Road</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>June 26, '60</u>	
PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim,</u>		<u>Edgewater, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-28-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cont</u>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sins</u>		ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 29 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>		

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6574

CERTIFICATE OF DEATH

06532

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>408 Virginia Avenue</b>											
3. NAME OF DECEASED (Type or print) First <b>Mary</b>		Middle <b>Edna</b>		Last <b>Smith</b>		4. DATE OF DEATH Month <b>6</b>		Day <b>14</b>		Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/9/92</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b>		IF UNDER 24 HRS. Days <b>14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Alexander Williams</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Quickly</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Hypostatic</b> <b>443X</b> DUE TO Arteriosclerotic Hypertension Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>Since Admission</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----											
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----		(State) -----			
21. I certify that (I) (this hospital) attended the deceased from <b>5/25</b> <b>1960</b> , to <b>6/14</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>6/14</b> <b>1960</b> , and that death occurred at <b>7:00</b> A.M. from the causes and on the date stated above.													
22a. SIGNATURE <b>L. Benedict, M. D.</b>		22b. DATE <b>6/14/60</b>		22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/18/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Rest</b>		23d. LOCATION (City, town, or county) <b>Towson, Balto. Co. Md.</b>		(State) <b>Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Phatman</b>		ADDRESS <b>1701 McBrat St</b>		25a. REC'D BY REGISTRAR <b>IN 17 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>							



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**6526** **CERTIFICATE OF DEATH**

06533

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>5 Days 10</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>5 Bestgate Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Wilson</b>		First <b>Wilson</b>		Middle <b>SMOTHERS, Sr.</b>		Last <b>SMOTHERS, Sr.</b>	
4. DATE OF DEATH <b>June 6 1960</b>		Month <b>June</b>		Day <b>6</b>		Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 31 - 1888</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GENERAL UTILITIES</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Wesley Smothers</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Harris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>W.W.I 32-10-2815</b>		17. INFORMANT <b>Marguerite Smothers-Annapolis-Md.</b>		Address <b>Best Gate - Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute leukemia</b>            204.3 DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____            DUE TO (c) _____</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____ 19 _____, to <b>June 6, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 6, 1960</b> , and that death occurred at _____ M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Therese H. Johnson M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>6/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>T. H. Johnson</b>				22d. ADDRESS <b>37 Calvert St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-9-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CARVER MEM. PARK</b>		23d. LOCATION (City, town, or county) <b>LAUREL Md</b> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Hicks III</b>				ADDRESS <b>ANNAPO LIS - Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 9 1960</b>	
				25b. REGISTRAR'S SIGNATURE <b>Christina S. Kneass</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6575 CERTIFICATE OF DEATH 06534

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>3 yrs. 9 mos.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Darlington</b>		12X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		d. STREET ADDRESS <b>unknown</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph C. Spriggs</b>		4. DATE OF DEATH <b>June 30, 1960</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 27, 1882</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR <b>19</b> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown (laborer)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>218-05-4480</b>	
17. INFORMANT Address <b>Mrs. Laura R. Moladi-Worker D.P.W. Bel Air</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inoperable carcinoma prostate</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>177X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>September 27, 1960</b> to <b>June 30, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 18, 1960</b> , and that death occurred at <b>8:15 A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James M. Pair</b>		22b. DATE SIGNED <b>June 30, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		22d. ADDRESS <b>400 N. Carrollton Avenue Balto. 23, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 5, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Berkley Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Darlington, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elmer E. Bullock - Harford County, Md.</b>		25. REC'D BY REGISTRAR <b>DATE JUL 6 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06535**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundle Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>			c. LENGTH OF STAY IN 1b <b>1 1/2 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>27 Brookfield Rd.</b>				d. STREET ADDRESS <b>Same</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>(MATTIE)</b> Middle <b>Martha</b> Last <b>Philemina Stewart</b>				4. DATE OF DEATH Month <b>6</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/13/84</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Alleghany Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James J. Rowan</b>				14. MOTHER'S MAIDEN NAME <b>Elizibeth Arnold</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. R. M. Marley (Granddaughter)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Arterio-sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>  <b>?</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>G. H. Faubert</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Dr. G. H. Faubert</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-11-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodhaven Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Home 130 E Fort Ave H 30</b>				24a. REC'D BY REGISTRAR <b>JUN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6527

CERTIFICATE OF DEATH

06536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>19 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>SUNDERLAND</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25 "1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary-Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benj. C. Sunderland</b>		14. MOTHER'S MAIDEN NAME <b>Mary G. Isaac</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-7611a</b>	
17. INFORMANT <b>Mrs Herbert Sunderland</b>		Address <b>Severna Park Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>4 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1955</b> , to <b>June 1960</b> that I last saw the deceased alive on <b>June 7, 1960</b> and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Severna Park, Maryland</b> DATE SIGNED ACTUAL SIGNATURE <b>Francis I. Codd</b> M.D. PHYSICIAN'S NAME (Type) <b>Francis I. Codd M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June, 10 "1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Ellis Lamoreau</b>		ADDRESS <b>1003 W. Balto. St.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

1003 N. Balto. St. Baltimore, Md. 10100  
Baltimore, Md. 10100

1003 N. Balto. St. Baltimore, Md. 10100  
Baltimore, Md. 10100

1003 N. Balto. St. Baltimore, Md. 10100  
Baltimore, Md. 10100

1003 N. Balto. St. Baltimore, Md. 10100  
Baltimore, Md. 10100

1003 N. Balto. St. Baltimore, Md. 10100  
Baltimore, Md. 10100



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6577

06537

Item 7 Film 265-6-27-60 et

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>1 year 3 mo. 16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle <b>Thomas</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>6</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1900</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b> Hours <b>19</b> Min. <b>60</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>-----</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. <b>10</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/7</b> <b>1960</b> , to <b>6/15</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>6/15</b> <b>1960</b> , and that death occurred at <b>8:58</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED <b>6/16/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>				22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Buried</b>		<b>6/22/60</b>		<b>St. Calvary Cem. A. A. Co. Md.</b>		<b>Calvary</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Rayner Sanders</b>				25. REC'D BY REGISTRAR <b>217 E. Preston St.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	
DATE <b>JUN 21 '60</b>							

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2. Billings

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6578 **CERTIFICATE OF DEATH**

06538

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hosp.</u>		d. STREET ADDRESS <u>11155 Stricken ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Tate</u> Middle <u>Tompkins</u> Last <u>Tompkins</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-1906</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. H</u>	
13. FATHER'S NAME <u>Charlie Ferguson</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Alexander</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>UNK</u>	
17. INFORMANT <u>CHART.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>SEPTICEMIA</u> DUE TO (c) <u>DECUBITAL ULCERS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME ASSOC. WITH GENERALIZED ARTERIOSCLEROSIS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/4/55</u> to <u>6/4/60</u> , that (I) (we) last saw the deceased alive on <u>6/4/60</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. BENEDICT M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		22d. ADDRESS <u>CROWNVILLE STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/9/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>		23d. LOCATION (City, town, or county) (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George D. Nelson</u>		25a. REC'D BY REGISTRAR <u>JUN 7 '60</u>	
ADDRESS <u>1348 W Calhoun St</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	



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## CERTIFICATE OF DEATH

06539  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jewell</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jewell Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Dunkirk Md.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAURICE E. TURNER</u>				4. DATE OF DEATH Month Day Year <u>June 8 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1892</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Turner</u>				14. MOTHER'S MAIDEN NAME <u>Annabelle Gibson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-16-1046</u>		17. INFORMANT <u>Mrs. Florence Turner</u>		Address <u>Jewell Road Dunkirk, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-10-1959</u> to <u>5/8</u> 19 <u>60</u> that I last saw the deceased alive on <u>5/8/60</u> 19 <u>60</u> , and that death occurred at <u>130 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Huntingtown, Md.</u> DATE SIGNED <u>5/9/60</u>							
ACTUAL SIGNATURE <u>G. J. Weems</u> PHYSICIAN'S NAME (Type) <u>Dr. George J. Weems</u>				M.D. <u>Huntingtown, Md.</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 10, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>A. A. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home Owings Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06540

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>A.A. Co</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Me</u> b. COUNTY <u>Ad</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Annapolis</u>		c. LENGTH OF STAY in 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA. U.S. NAVAL HOSPT.</u>				d. STREET ADDRESS <u>204 S. Cherry Grove Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Otis</u> Middle <u>A</u> Last <u>Van Denburgh</u>				<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>7</u> Year <u>1960</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Sept 10 - 1892</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>6</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>MECHANICAL Eng.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S.N.E.E.S.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>TROY N.Y.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>OTIS A. VAN DENBURGH</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>GERTRUDE DEFREEST</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>W. Van I</u>		<b>17. INFORMANT</b> <u>Elizabeth S. Van Denburgh</u> (2)			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease</u> DUE TO <u>434.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ischemic</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> o. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>E. Linhardt</u>				<b>DATE SIGNED</b> <u>6-7-60</u>			
<b>EXAMINER'S NAME (Type)</b> <u>E. Linhardt</u>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6-9-1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Hellenet Mem. Cem.</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Annapolis</u>		<b>(State)</b> <u>Me</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Scyler</u>		<b>ADDRESS</b> <u>Annapolis Me</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JUN 10 '60</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALLIANCE STATE DEPARTMENT OF HEALTH - 3A - 1000  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6528

CERTIFICATE OF DEATH

Reg. Dist. No.

06541

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL - Riva</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>	
d. STREET ADDRESS <b>Glen Isle Estates</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>Allen</b> Last <b>WADDELL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1960</b>
9. AGE (In years lost birthday) yrs. <b>8</b> Months <b>4</b> Days <b>30</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Stanley Leroy WADDELL</b>	
14. MOTHER'S MAIDEN NAME <b>Fannie Mae TOY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congenital malformation of heart and aorta</b> <b>754.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atrophy of left ventricle</b> DUE TO (c) <b>atrophy proximal portion of aorta</b> <b>100.00</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 7, 1960</b> to <b>June 15, 1960</b> , that I lost sows the deceased olive on <b>June 15, 1960</b> , and that death occurred at <b>3:20 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edith Rodler</b>		ADDRESS (Street, city or town, state) <b>45 Franklin St., Annapolis, Md.</b>	
DATE SIGNED <b>6/16/60</b>		PHYSICIAN'S NAME (Type) <b>Edith Rodler</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7 June 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. J. Sangster</b>		ADDRESS <b>Glen Burnie, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2063253XL5



6581

## CERTIFICATE OF DEATH

06542  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft Geo G. Meade</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Odenton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Army Hospital, Ft Geo G. Meade, Md</b>				d. STREET ADDRESS <b>1216 Annapolis Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Suzanna</b> Middle <b>Marie</b> Last <b>Ward</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>N/A</b>		8. DATE OF BIRTH <b>5 June 60</b>	
9. AGE (In years lost birthday) yrs.		10. AGE (In years lost birthday) yrs.		11. AGE (In years lost birthday) yrs.		12. AGE (In years lost birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>Fredrick D. Ward</b>				14. MOTHER'S MAIDEN NAME <b>Rosemarie Boller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>Father</b>				Address <b>1216 Annapolis Road, Odenton, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12 June</b> , 19 <b>60</b> , to <b>12 June</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12 June</b> , 19 <b>60</b> , and that death occurred at <b>11:30A</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>USA Hospital Ft Geo G Meade, Md</b> DATE SIGNED <b>12 June 60</b>							
ACTUAL SIGNATURE <b>Roy M. Slezak</b> M.D.							
PHYSICIAN'S NAME (Type) <b>ROY M. SLEZAK, CAPT., M.C.</b> <b>U.S. Army Hospital, Ft Geo G. Meade, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>14 June 1960</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>							
22d. LOCATION (City, town, or county) (State) <b>Glen Burnie Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Singleton-Funeral-Home-Robert P. Ware</b> ADDRESS <b>Glen Burnie, Maryland</b>							
24a. REC'D BY REGISTRAR <b>JUN 15 60</b> DATE							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Francis</b>							

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050202XV1

# CERTIFICATE OF DEATH

6581

(M)

Age	Sex	Color	Marital Status	Place of Birth	Usual Residence	Address at Time of Death	Occupation	Education	Religion	Signature of Physician	Signature of Registrar	Signature of Informant
45	M	W	Married	England	London	10, Grosvenor Road, London	Banker	High School	Anglican	[Signature]	[Signature]	[Signature]
Date of Death	Time of Death	Place of Death	Cause of Death	Immediate Cause	Underlying Cause	Manner of Death	Signature of Medical Examiner	Signature of Coroner	Signature of Jury	Signature of Registrar	Signature of Informant	Signature of Witness
Jan 15, 1950	10:30 AM	London	Myocardial Infarction	Coronary Atherosclerosis	Arteriosclerosis	Natural	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06543**

6582

1. PLACE OF DEATH a. COUNTY <b>A.A.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>JAMES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lernedale</b>				c. LENGTH OF STAY IN 1b <b>35 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vista Ave - (South)</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LeRoy</b> Middle <b>Michael</b> Last <b>Wasmus</b>				4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>m</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb - 27 - 1911</b>	
9. AGE (In years last birthday) <b>49 yrs.</b>		IF UNDER 1 YEAR Months <b>49</b> Days <b>18</b> Hours <b>19</b> Min.		IF UNDER 24 HRS Months <b>49</b> Days <b>18</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheller - Shipyard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Frederick H. Wasmus</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca M. Wilder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>216-09-6787</b>		17. INFORMANT <b>LeRoy Wm Wasmus - Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.1</b> DUE TO <b>Thyroidatic Ca - origin unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>In Liver - Brain &amp; glands</b> DUE TO (c) <b>6-7th</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6-7th</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Had biopsy at University Hosp.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Mar 4, 1960</b> , to <b>6/18, 1960</b> , that I last saw the deceased alive on <b>6/18/60</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chas. L. Ball Jr.</b>				DATE SIGNED <b>6/18/60</b>			
PHYSICIAN'S NAME (Type) <b>Chas. L. Ball Jr.</b>				ADDRESS (Street, city or town, state) <b>Lincoln</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-21-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill An</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McColly Funeral Home 130E Fort Ave</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06544

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>20 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Galesville</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>WATKINS</b> Last <b>WATKINS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1900</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>12</b>	11. IF UNDER 24 HRS. Hours <b>12</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joshua Watkins</b>		14. MOTHER'S MAIDEN NAME <b>Mary Foster</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-035158</b>	
17. INFORMANT <b>Mamie Watkins</b>		Address <b>Galesville Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emboli</b> DUE TO <b>Perinephric abscess</b> DUE TO <b>Metastatic stricture</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 weeks</b> <b>20 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 23, 1960</b> to <b>June 11, 1960</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>June 11, 1960</b> , and that death occurred at <b>6:00 A.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Edwin Davis, Jr.</b>		22b. DATE <b>6:00 A.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin Davis, Jr.</b>		22d. ADDRESS <b>98 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-15-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chew's Memorial</b>		23d. LOCATION (City, town, or county) <b>Galesville Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Keese</b>		25a. REC'D BY REGISTRAR <b>15 80</b>	
ADDRESS <b>Anna Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hall</b>	



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

10558

DATE: 10/10/68

TO: DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10/10/68

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

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55. [Illegible]

56. [Illegible]

57. [Illegible]

58. [Illegible]

59. [Illegible]

60. [Illegible]

61. [Illegible]

62. [Illegible]

63. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filled in by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
1  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>				c. LENGTH OF STAY IN 1b <b>3 mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>117 Doris Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Susan Elizabeth Weiss</b>				4. DATE OF DEATH Month Day Year <b>September 28 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 29, 1895</b>	
9. AGE (In years lost birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Joseph Ragan</b>				14. MOTHER'S MAIDEN NAME <b>Bridget Ready</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs. Frances R. Parsick 117 Doris Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 1422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASC + HD.</b> DUE TO (c) <b>3 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>July 1960</b> , 19 to <b>28 Sept 1960</b> , that (I) (we) last saw the deceased alive on <b>27 Sept 1960</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Andrew R. Sosnowski</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Sept. 29, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew R. Sosnowski</b>				22d. ADDRESS <b>4016 Ritchie Hwy. Balto. 25, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 1, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Schuykill Memorial Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Schuykill Haven, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Force</b>				ADDRESS <b>4001 Ritchie Hwy. Balto 25, Md</b>		25a. REC'D BY REGISTRAR <b>OCT 6 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6583

CERTIFICATE OF DEATH

06545

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>16yrs. 6mo. 18da.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>410 Ogston Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lloyd</b> Middle <b>White</b> Last <b>White</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1907?</b>	
9. AGE (In years last birthday) <b>52?</b> yrs.		10. IF UNDER 1 YEAR Months <b>52?</b> Days <b>22</b> Hours <b>16</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Calvert Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>			
13. FATHER'S NAME <b>Jack White</b>				14. MOTHER'S MAIDEN NAME <b>Mary Smallwood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address <b>---</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> DUE TO <b>Generalized Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Carcinoma of stomach</b> (c) <b>---</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome with Central Nervous System Syphilis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>---</b> <b>p. m.</b> <b>---</b> <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b> (County) <b>---</b> (State) <b>---</b>				21. I certify that I attended the deceased from <b>December 4, 1943</b> to <b>June 22, 1960</b> , that I last saw the deceased alive on <b>June 22, 1960</b> , and that death occurred at <b>5:50 a. m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>June 22/60</b>			
PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>				Crownsville State Hospital, Md. 6/22/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/27/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall P. Hays</b> ADDRESS <b>638 n. GILMORE ST</b>				24a. REC'D BY REGISTRAR <b>---</b> DATE <b>JUN 24 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneel</b>	

CERTIFICATE OF DEATH

6583

Married

John Doe

110 Green Street

White

John Doe

Hospital No. 1234

1234

Signature of Doctor

Signature of Doctor

Signature of Doctor

Signature of Doctor

Signature of Doctor

Signature of Doctor

Signature of Doctor

Signature of Doctor

Signature of Doctor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6584

## CERTIFICATE OF DEATH

Reg. Dist. No.

06546

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena R.F.D.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Pasadena R.F.D.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9th. St. + Catherine St. Green Haven</b>				d. STREET ADDRESS <b>9th. St. + Catherine St. Green Haven</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>S.</b> Last <b>WHITTAKER</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>13-March 1906</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Oil</b>		11. BIRTHPLACE (State or foreign country) <b>Silverspring, md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert S. Whittaker, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Lula Croley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-18-9482</b>		17. INFORMANT Address <b>Mrs. Alice C. Jensen, Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA STOMACH</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHIECTASIS</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/16/60, 1960</b> , to <b>4/20, 1960</b> , that I last saw the deceased alive on <b>4/20, 1960</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9471 Ft. Smallwood Rd. Pk 2160</b> DATE SIGNED ACTUAL SIGNATURE <b>J. Brady Smith</b> M.D. PHYSICIAN'S NAME (Type) <b>J. BRADY SMITH PASADENA, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>23 June 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Green Haven Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Singleton</b> ADDRESS <b>Green Haven, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED LAST NAME FIRST MIDDLE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF DEATH MONTH DAY YEAR	
PLACE OF DEATH CITY TOWN OR VILLAGE COUNTY		TIME OF DEATH HOUR MINUTE	
AGE YEARS MONTHS DAYS		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
OCCUPATION TRADE OR PROFESSION		CAUSE OF DEATH (To be filled by physician)	
PLACE OF BIRTH CITY TOWN OR VILLAGE COUNTY		DATE OF BIRTH MONTH DAY YEAR	
MARRIAGE DATE OF MARRIAGE PLACE OF MARRIAGE		PREVIOUS MARRIAGES DATE OF MARRIAGE PLACE OF MARRIAGE	
EDUCATION SCHOOL ATTENDED DEGREE		SERVICE ARMY NAVY AIR FORCE MARINE CORPS	
RELIGION CHURCH		SIGNATURE OF DECEASED DATE	
SIGNATURE OF PHYSICIAN DATE		SIGNATURE OF REGISTRAR DATE	

MASSACHUSETTS DEPARTMENT OF HEALTH - BELLINGHAM

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Laurel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 1 - Box 183</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Samuel Williams</u> First Middle Last		4. DATE OF DEATH <u>June 6 - 1960</u> Month Day Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-1882</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Williams</u>		14. MOTHER'S MAIDEN NAME <u>India Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MISS. Edward Curleton Hughes</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Quick</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GUSTAVE H. FAUBERT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/6/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-11-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>LAUREL, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles G. Cooper</u> ADDRESS <u>CHARLES G. COOPER - 512 N. CARROLLTON AV.</u>		24a. REC'D BY REGISTRAR <u>JUL 11 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Frank</u>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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6530

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06548

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>207 Severn Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Dorothea</b> Middle <b>E</b> Last <b>WISEMAN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1890</b>		9. AGE (In years lost birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ferdinand Freiderich</b>				14. MOTHER'S MAIDEN NAME <b>Wilhmieni ( Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Fred A. Wiseman- Son- Severna Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>short</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/2</b> 19 <b>60</b> to <b>June 2,</b> 19 <b>60</b> , that (I) <b>last</b> saw the deceased alive on <b>June 2,</b> 19 <b>60</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard N. Peeler</b>		22b. DATE <b>7:05P.</b>		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard N. Peeler</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 6, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Arnold, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 8 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

1930

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6586

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Ann Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>805 Dale Rd</u>		e. STREET ADDRESS <u>1 805 Dale Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Henry</u> Last <u>WOLF</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 13, 1892</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Wolf</u>		14. MOTHER'S MAIDEN NAME <u>ANNA FINGERHAUSEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW I 090-10-7287</u>		17. INFORMANT <u>EDNA WOLF</u> Address <u>805 Dale Rd Glen Burnie, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per time for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Hodgkins Disease, Apical</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u> <u>3 days.</u> <u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/12</u> , 19 <u>60</u> , to <u>6/4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/4</u> , 19 <u>60</u> , and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>715 COTTER RD</u> DATE SIGNED <u>6/4/60</u> ACTUAL SIGNATURE <u>R.W. Prichard</u> M.D. <u>R. W. PRICHARD</u> PHYSICIAN'S NAME (Type) <u>R. W. PRICHARD</u> <u>Glen Burnie, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 7 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>NEW YORK NEW YORK</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; KURTZ, Glen Burnie</u>		24a. REC'D BY REGISTRAR <u>JUN 7 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6583



PLACE OF BIRTH STATE OF MARYLAND COUNTY OF BALTIMORE		PLACE OF DEATH STATE OF MARYLAND COUNTY OF BALTIMORE	
DATE OF BIRTH JAN 1 1900		DATE OF DEATH JAN 1 1900	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
OCCUPATION LABORER		OCCUPATION LABORER	
MARITAL STATUS SINGLE		MARITAL STATUS SINGLE	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH STATE OF MARYLAND COUNTY OF BALTIMORE		PLACE OF BIRTH STATE OF MARYLAND COUNTY OF BALTIMORE	
DATE OF BIRTH JAN 1 1900		DATE OF BIRTH JAN 1 1900	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
OCCUPATION LABORER		OCCUPATION LABORER	
MARITAL STATUS SINGLE		MARITAL STATUS SINGLE	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH STATE OF MARYLAND COUNTY OF BALTIMORE		PLACE OF BIRTH STATE OF MARYLAND COUNTY OF BALTIMORE	
DATE OF BIRTH JAN 1 1900		DATE OF BIRTH JAN 1 1900	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
OCCUPATION LABORER		OCCUPATION LABORER	
MARITAL STATUS SINGLE		MARITAL STATUS SINGLE	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	

ADD TO THIS CERTIFICATE

RECEIVED JAN 1 1900  
 BALTIMORE, MARYLAND  
 STATE DEPARTMENT OF HEALTH

# Item 8 Film 264 6-13-60 et 6587 6587 06550 Reg. Dist. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> c. LENGTH OF STAY IN 1b <u>60</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sann's Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>113 Central Ave. S.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>Hamilton</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4th</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 9, 1879</u>			
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (ret.)</u>		11. BIRTHPLACE (State or foreign country) <u>A. A. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Elizah Wood</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Shelby</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Blanche Rollins</u>		Address <u>Same as #2</u>			
MEDICAL CERTIFICATION						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO <u>Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Generalized Edema</u> DUE TO <u>Generalized Edema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Infarct - Paralytic - Residual</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years</u> <u>1 month</u>	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/18</u> , 19 <u>60</u> , to <u>6/4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/3/60</u> , and that death occurred at <u>1 A</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Odenton Md</u> DATE SIGNED <u>6/6/60</u>									
ACTUAL SIGNATURE <u>DR. JOSEPH L. LEE</u>		PHYSICIAN'S NAME (Type) <u>ORRONTON, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 7, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Park, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Single</u>		ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 8 60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6531

## CERTIFICATE OF DEATH

Reg. Dist. No. 06551

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>217 HANOVER ST.</u>		d. STREET ADDRESS <u>217 HANOVER ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>J.</u> Last <u>WORK</u>		4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EVAN M. JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH SEAMEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>WM O. MC DOWELL</u>	
17. INFORMANT <u>WM O. MC DOWELL</u>		Address <u>508 BALDWIN RICHMOND, VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>D.O.A.</u> <u>252.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thyrototoxic Heart Disease</u> DUE TO (c) <u>8 min</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 1960</u> to <u>6-3-1960</u> , that I last saw the deceased alive on <u>6-2-1960</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipl-y</u>		ADDRESS (Street, city or town, state) <u>121 Cathedral St</u> DATE SIGNED <u>6-5-60</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipl-y</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>6-6-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. LINCOLN</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor + Son</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

